

Docket Management Comment Form
Docket: CMS-1502-P - Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2006
Temporary Comment Number: 20769

SEP 8 2005

Submitter: Mrs. Suzanne Shaw	Date: 09/01/05
Organization: Santa Cruz Medical Foundation	
Category: Nurse Practitioner	
Issue Areas/Comments	
General	
I strongly support changing the reimbursement structure for Santa Cruz County since we live in an area which is one of the highest cost of housing and living and we receive a much lower reimbursement than our neighboring counties who have a similar cost of living profile. It is definitely time to correct the great discrepancy in our area. Thank you for your support in this effort. Sincerely, Suzanne Shaw, PNP	
Attachments	
No Attachments	

Print - Print the comment
Exit - Leave the application

Conley, Wilson & Ballou

302

620 Petaluma Boulevard North, Suite C
Post Office Box 750129
Petaluma, California 94575-0129

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E-mail: cwbtaxdudes@sbcglobal.net

SEP 9 2005

5 September 2005

Centers for MediCare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1502-P
PO Box 8017
Baltimore, Maryland 21244

Re: GPCIs

Dear Gentlepersons:

I understand that MediCare is proposing to create a new payment schedule for Sonoma County, California, health care providers. We would like to address some specific concerns from the perspective of a professional income tax service with many retired clients:

- Santa Rosa and Sonoma County now rank with retirement destinations such as Clearwater, St. Petersburg, and Miami, Florida.
- Among cities with a population of 100,000 or more, Santa Rosa is sixth in the United States for the highest percentage of people 85 and older.
- According to State of California Department of Finance, seniors 60 and older represent 16.6% of the total population in Sonoma County, with a projected rate of change of plus 196% by 2020.

Amid the astounding growth in our elder population, Sonoma County is facing strains on the health care delivery network that are unacceptable to MediCare recipients:

- The number of practicing physicians in Sonoma County has not kept pace with local population growth. From 1995 to 2002, the population increased 13%, but the number of practicing physicians increased by only 4%.
- As of July 2005, 60% of Sonoma County primary care physicians were NOT accepting new MediCare patients. **This is unacceptable!**
- Many physicians are leaving our county to practice where reimbursement is more favorable. As a result, many specialties are under-supplied. For example, we have only two gerontologists in the county for more than 76,000 seniors.

The proposed new reimbursement schedule should increase MediCare payments so that they can more closely match actual practice expenses, helping Sonoma County physicians and other health professionals improve the quantity and quality of care they deliver to MediCare beneficiaries and other patients. This schedule change would also aid efforts to recruit and retain physicians in the county, which has a large MediCare population. I fully support your proposal to change Sonoma County's payment rates, and I appreciate the opportunity to comment on this important issue.

Sincerely,



cc: Sonoma County Medical Association

Enrolled to practice before the Internal Revenue Service

SEP 9 2005

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THE CLEVELAND CLINIC
FOUNDATION 

Michael Roizen, M.D.
Chairman
Division of Anesthesiology,
Critical Care Medicine and
Comprehensive Pain Management/E30
Phone: 216-444-2595
Fax: 216-444-4382

August 30, 2005

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P
P.O. Box 8017
Baltimore, MD 21244-8017

RE: The proposed rule change will help solve the shortage and will dramatically decrease Medicare and Medicaid costs. Support for elimination of 50% reduction in Medicare payment to teaching anesthesiologists.

Dear Sirs:

Let me tell you why I think the physician teaching rule change proposed for anesthesiologists is a **PENNY FOOLISH BUT POUND WISE THAT WILL RESULT IN GREATER SAVINGS** - anesthesiologists and nurse anesthetists are in short supply. This proposed rule change will increase incentives to train physician anesthesiologists. That rule will minimize or eliminate the current shortage of anesthesiologists that is driving up subsidies that hospitals have to pay to recruit and retain anesthesiologists. So this rule that may cost Medicare some dollars in the short run will cause a long term substantial cost reduction.

Gosh, solve a shortage, right an inequity, and reduce costs in the long run - could any leader let alone bureaucrat tolerate a win-win-win proposal? There are now approximately 9000 anesthesia providers short currently in the United States or roughly an 11% shortage. This has driven up subsidies for on call and others to the point where hospitals average paying \$130,000 extra over fees

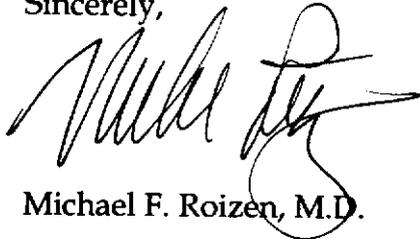
Medicare and Medicaid
August 30, 2005
Page Two

collected by commercial and Medicare insurance per provider of anesthesia services. These subsidies are greater at teaching institutions because of the reimbursement "disadvantage" of caring for more Medicare and Medicaid patients.

What will happen if you cure the shortage with this rule? Guess what, you will drive subsidies down and the net cost to Medicare will be a pound saved for every penny you spend (oh yes, they are passed through to you) - thus I believe it is in your best interest to accept this rule change. In fact if you want to decrease costs for service while increasing quality you would do just this.

Thus the proposed action, while it seems to spend money, will actually save Medicare more (I guess it is like tax proposal in the Reagan administration - cutting taxes increased government revenue.) Thanks very much for your consideration of accepting the proposed change because it would decrease government expenditure and increase quality. I can't believe you're considering something so rational.

Sincerely,

A handwritten signature in black ink, appearing to read "Michael F. Roizen". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

Michael F. Roizen, M.D.

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P/TEACHING ANESTHESIOLOGISTS
P.O. Box 8017
Baltimore, MD 21244-8017

SEP 9 2005

Dear Dr. McClellan:

I am an anesthesiologist at Duke University Medical center and I'm writing today to urge you to change in the current payment policy for teaching anesthesiologists. The current system discriminates financially against those of us anesthesiologists who choose to work in the academic setting. This leaves the academic workplace less desirable and thus many of our brightest faculty members are abandoning academics for private practice. We, the collective anesthesiologists at academic institutions, are responsible for training the anesthesiologists of tomorrow as well as advancing the practice of anesthesia through research endeavors. The impact of poor reimbursement has impaired our ability to recruit and keep many brilliant anesthesiologists. The impact will be more profound the longer this is allowed to continue. As the patient population ages and concurrent medical diseases of patients undergoing anesthesia becomes ever more complicated the impact of poor quality training and slow advancement of knowledge will be significant. The economic impact at my institution is such that we now earn roughly half that of our private practice counterparts, and, worse than that, we all expect the gap only to widen. I'm a young anesthesiologist who takes great interest in teaching residents. I constantly reevaluate my position in academics. This is my second academic job, and my plan for the future, at this time, includes a transition to the private sector. My wife is also a physician and each of us has medical school loans that exceed the price of our house. I am only asking that I be treated in a similar manner as my colleagues in surgery and medicine and thus be reimbursed fully for each case I supervise instead of only 50%.

Sincerely,



Wade Weigel, M.D.
Assistant Clinical Professor of Anesthesiology

weige002@mc.duke.edu
(919) 681-4168
Duke University Medical Center
DUMC Box 3094
Durham, NC 27710

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SEP 9 2005



September 7, 2005

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1502-P
P.O. Box 8017
Baltimore, MD 21244-8017

Dear Sir/Madam:

The American Association for Clinical Chemistry (AACC) appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) proposed rule to revise the physician fee schedule for 2006. Specifically, we offer the following comments on the flow cytometry recommendations.

AACC agrees with CMS's recommendations to increase the payment amounts for flow cytometry codes 88184 and 88185. We believe the current payment amounts do not accurately reflect the input costs needed to provide these services. Therefore we support:

- Changing the staff type in the service (intra) period in both CPT codes 88184 and 88185 to cytotechnologist at \$0.45 per minute in lieu of the current \$0.33 for a laboratory technician;
- Increasing the antibody costs for CPT codes 88184 and 88185 from \$3.54 to \$8.50; and
- Adding a computer, printer slide strainer, biohazard hood and FACS washing assistant to CPT code 88184 and a computer and printer to CPT code 88185.

We believe these changes will more accurately reimburse clinical laboratories for the cost of performing flow cytometry testing.

By way of background, AACC is the principal association of professional laboratory scientists--including MDs, PhDs and medical technologists. AACC's members develop and use chemical concepts, procedures, techniques and instrumentation in health-related investigations and work in hospitals, independent laboratories and the diagnostics industry worldwide. The AACC provides international leadership in advancing the practice and profession of clinical laboratory science and its application to health care. If you have any questions, please call me at (314) 362-1503, or Vince Stine, Director, Government Affairs, at (202) 835-8721.

Sincerely,

A handwritten signature in black ink, appearing to read "MG Scott", is written over a horizontal line.

Mitchell G. Scott, PhD
President, AACC

SEP 9 2005

. Sept. 6, 2005

Centers For Medicare & Medicaid Services
Dept. Of Health & Human Services
Attn: CMS-1052-P
Baltimore, MD 21244-8017

Subj: GPCIs

Dear Government Officials:

I am a senior citizen on medicare in Rohnert Park, CA. in the county of Sonoma. There have been an alarming number of medical providers in this area who have either gone bankrupt or are close to it. Simply put, they have not had sufficient reimbursement from medicare for them to survive. How would you like to provide an important service as medical care and yet not be paid adequately for it? I think not. We seniors are finding fewer and fewer medical providers available to us as a result of this terrible situation.

To correct this injustice you must approve the reimbursement rate by 8 percent as has been proposed recently. Sonoma County is not a "rural" county by any stretch of the imagination. Your own figures tell you that. We plead with you to right this disparity and to give us the peace of mind we deserve in our old age. Thank you.

Sincerely,

Joseph J. Perry



September 4, 2005

Department of Anesthesiology

Philip D Lumb, MB, BS, FCCM
Professor and Chairman

**Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P
Mail Stop C4-26-05
7500 Security Blvd
Baltimore, MD 21244-1850**

Re: Teaching Anesthesiologists

The Medicare Fee Schedule changes released on August 1, 2005 do not include a proposed correction to the current policy of paying teaching anesthesiologists 50% of the fee for each of two directly supervised but concurrent resident teaching cases. The language indicates that the current rule is discriminatory and does not accommodate the needs of anesthesiology or the patients this medical specialty and its subspecialties (Critical Care Medicine, Pain Medicine, Pediatric Anesthesiology, etc.) support.

The Joint Commission on the Accreditation of Hospital Organizations (JCAHO) recently made assessment of pain the fifth "Vital Sign". Anesthesiology is the leading medical specialty with specific teaching interests in managing acute and chronic pain, and in palliative medicine and management of the terminally ill.

Critical Care Medicine was first recognized in anesthesiology, and it is apparent that as the population ages, specialists in this vital field are necessary. All manpower studies indicate that there is a current shortage of as many as 20,000 physicians in this field alone despite the fact that the Leapfrog Group has indicated that 24 * 7 coverage of critical care units by a specialist is anticipated to reduce length of stay and improve outcome. Not only are immediate hospital cost savings important, but also the reduction in morbidity should improve quality adjusted life years (QALY) for the patients and further reduce society's costs.

Specialized anesthesia care in managing Trauma, Pediatrics, Obstetrics, Cardiac Surgery, Neurological Surgery and all types of surgical care requiring general or regional anesthesia are best managed personally by or under the management of an anesthesiologist. Currently there is a manpower shortage in the specialty, and the academic departments charged with training the

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Teaching Anesthesiologists
September 4, 2005

next generation of providers are under significant financial pressure. The current Medicare Rule will do nothing to ease the constraints and may force a number of departments to close.

Furthermore, and despite the fact that minimally invasive surgical techniques and the development of invasive, percutaneous procedures in cardiology and neuro-radiology were anticipated to decrease the need for trained anesthesiologists, it has become apparent that the reverse has occurred. Contrary to the belief that light sedation is uniformly safe and can be administered by non-anesthesiology personnel, overall direction by anesthesiologists is required and has been demonstrated to provide a level of safety and improved outcomes that is unavailable in alternate environments.

I represent and work in the Keck School of Medicine of the University of Southern California's Department of Anesthesiology. Our Department provides service to Los Angeles County General Hospital and the affiliated Women's and Children's Hospital (LAC+USC MC) and also to the University of Southern California University Hospital (USCUH), the Doheny Eye Institute and the Norris Cancer Center. Additionally, the Department of Anesthesiology at the Children's Hospital of Los Angeles (CHLA) is part of our Department. We currently train 54 residents across all three years and employ 52 anesthesiologists. We are responsible for covering 50 anesthetizing locations every morning and maintain 24 * 7 coverage for all six institutions as needed. Emergency services at LAC+USC MC support the nation's busiest penetrating trauma program for the citizens of Los Angeles; the US Navy has established its Trauma Training Program at our institution to provide "combat" experience to Navy surgeons, anesthesiologists and allied health professionals prior to deployment overseas.

Budgetary constraints are negatively impacting our ability to attract quality faculty and maintain the high teaching standards necessary to insure the future health of the American public. It is apparent that academic teaching centers are the cornerstone of the American health "safety net", and further reduction in our ability to maintain this service cannot be tolerated. The biggest competition to the academic centers is the robust private sector market in which the support of government sponsored and indigent care is far less than that noted in the teaching programs. The Medicare Fee Schedule change proposed by Anesthesiology is neither unique nor untested. Academic surgeons (who receive a far higher proportion of their usual fee through Medicare than do Anesthesiologists) can be reimbursed for supervising two concurrent surgical procedures by insuring their presence during the key portions of the surgical procedure. It is important to recognize that the individuals being

Page Three
Teaching Anesthesiologists
September 4, 2005

supervised are physicians with appropriately credentialed intermediate skills prior to participation in this teaching paradigm.

Anesthesiologists practice in an identical manner; we are penalized by 50% reimbursement. The periods of a surgical procedure in which the direct presence of an anesthesiologist is necessary are predictable. Perhaps more importantly, the coverage requirements of an academic practice supports emergency situations more effectively than solo practice; i.e. it is easier to assign personnel to help in an emergency when experienced faculties can be transferred to areas of acuity and unanticipated need. The Anesthesiology Residency Review Committee (RRC) of the Accreditation Council of Graduate Medical Education (ACGME) has a longstanding commitment to insuring the integrity of supervisory ratios and the experience acquired by residents prior to graduation, and I am confident you will find that the nation's accredited academic anesthesiology programs maintain these ratios diligently despite Medicare's discriminatory reimbursement policies.

In summary, I would like to reiterate the following:

- The current Medicare teaching anesthesiologist payment rule is unwise, unfair and unsustainable.
- Quality medical care, patient safety and an increasingly elderly Medicare population demand that the United States have a stable and growing pool of physicians trained in anesthesiology.
- Anesthesiology teaching programs like mine are suffering severe economic losses that cannot be absorbed elsewhere. We are a vital component of the medical emergency coverage for the city of Los Angeles.
- The CMS anesthesiology teaching rule must be changed to allow academic departments to cover their costs.
- Academic research in anesthesiology is also drying up as department budgets are broken by this arbitrary Medicare payment reduction.
- A surgeon may supervise residents in two overlapping operations and collect 100% of the fee for each case from Medicare. An internist may supervise residents in four overlapping outpatient visits and collect 100% of the fee for

Page Four
Teaching Anesthesiologists
September 4, 2005

each when certain requirements are met. A teaching anesthesiologist will only collect 50% of the Medicare fee if he or she supervises residents in two overlapping cases.

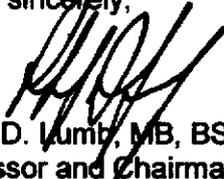
- This is not fair, and it is not reasonable.
- Medicare must recognize the unique delivery of anesthesiology care and pay Medicare teaching anesthesiologists on par with their surgical colleagues.

The Medicare anesthesia conversion factor is less than 40% of prevailing commercial rates; reducing that by 50% for teaching anesthesiologists results in revenue grossly inadequate to sustain the service, teaching and research missions of academic anesthesia training programs.

I look forward to resolution of this important issue. I shall be happy to answer any questions you may have or to clarify any details of this letter. I write with the support of our Hospital Administrators who are happy to endorse these statements. I understand the significant demands on the Medicare budget, but the future health of the nation's critically ill, injured and indigent patients rests with the current and future care provided by its academic centers. Intimately connected with current health care is the necessity to support the research and development of new strategies to support new requirements. The research mission of the academic centers must also receive priority attention.

Thank you for your consideration of this request. I look forward to the positive action of the agency on these issues.

Yours sincerely,



Philip D. Lumb, MB, BS, FCCM
Professor and Chairman
Department of Anesthesiology
Keck School of Medicine
University of Southern California

SEP - 9 2005

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n y m
NEW YORK METHODIST HOSPITAL
August 31, 2005

DEPARTMENT OF ANESTHESIOLOGY

506 SIXTH STREET, BROOKLYN, N.Y. 11215-9008 TEL 718/780-3279 FAX 718/780-3281

Centers for Medicare and Medicaid Services
Department of Health and Human Services

RE: CMS-1502-P TEACHING ANESTHESIOLOGISTS

The current Medicare teaching anesthesiologist payment rule is unwise, unfair and unsustainable. Quality medical care, patient safety and an increasingly elderly Medicare population demand that the United States have a stable and growing pool of physicians trained in anesthesiology. Right now, slots in anesthesiology residency programs are going unfilled because of ill-conceived Medicare policy that shortchanges teaching programs, withholding 50% of their funds for concurrent cases.

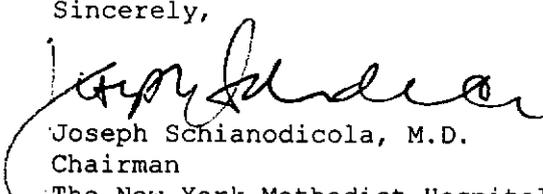
We currently have 13 residents 4 faculty openings in the New York Methodist Hospital Anesthesiology Program. This creates great inefficiencies in scheduling, personnel allocation, and case assignments. It is very difficult for us to recruit and retain faculty due to budget shortfalls and non-competitive salaries that can be directly attributed to the current Medicare teaching anesthesiologist policy. Anesthesiology teaching programs, caught in the snare of this trap, are suffering severe economic losses that cannot be absorbed elsewhere.

The CMS anesthesiology teaching rule must be changed to allow academic departments to cover their costs. Academic research in anesthesiology is also drying up as department budgets are broken by this arbitrary Medicare payment reduction.

A surgeon may supervise residents in two overlapping operations and collect 100% of the fee for each case from Medicare. An internist may supervise residents in four overlapping outpatient visits and collect 100% of the fee for each when certain requirements are met. A teaching anesthesiologist will only collect 50% of the Medicare fee if he or she supervises residents in two overlapping cases. This is not fair, and it is not reasonable.

Medicare must recognize the unique delivery of anesthesiology care and pay Medicare teaching anesthesiologists on par with their surgical colleagues. The Medicare anesthesia conversion factor is less than 40% of prevailing commercial rates. Reducing an already grossly inadequate reimbursement fee by 50% for teaching anesthesiologists will make us unable to sustain the service, and teaching and research missions of academic anesthesia training programs.

Sincerely,


Joseph Schianodicola, M.D.
Chairman

The New York Methodist Hospital
Anesthesiology Residency Program

SEP 12 2005

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**THE CLEVELAND CLINIC
FOUNDATION**



Roger M. Macklis, M.D.

Professor and Chairman

Department of Radiation Oncology - T29

Office: 216-444-5576

Appointments: 216-444-5571

Fax: 216-444-7595

E-mail: macklisr@ccf.org

August 29, 2005

Trish Crishock, Director, Health Policy and Economics,
Jenna Kappel, Assistant Director of Health Care Policy & Economics
The American Society for Therapeutic Radiology and Oncology
12500 Fair Lakes Circle
Suite 375
Fairfax, VA 22033-3882

**RE: Price / Cost Inputs for New CPT codes for SRS Treatment Delivery
Price of Cobalt-based and LINAC-based SRS systems are Nearly Identical**

Dear Ms. Crishock and Ms. Kappel:

I recently learned that the American Society for Therapeutic Radiology and Oncology (ASTRO) is currently developing recommendations for two new CPT codes for stereotactic radiosurgery (SRS) treatment delivery (complete course of treatment of cerebral lesion(s) consisting of one session)—one for multi-source Cobalt-based and one for linear accelerator/LINAC-based. I also understand that these codes will be for the technical component (equipment costs) only and that ASTRO has requested pricing information for the equipment.

We are fortunate to have both Cobalt-based and LINAC-based delivery systems at our institution and so I am familiar with the pricing/costs for both systems. I think it is important to point out that the prices for the Cobalt and LINAC systems are nearly identical. Further, the price differences between the two systems are so minimal most clinical experts, myself included, feel strongly that there should not be any distinction, especially for the purposes of recommending a payment rate for the technical component.

Medical technology for stereotactic radiosurgery is advancing at a rapid pace and providing substantial clinical benefits to a wide variety of patients for ever growing indications. For this reason, we appreciate ASTRO's taking the lead in obtaining appropriate codes for the technology so that providers are reimbursed and there are no financial barriers to patient access. The CPT/RUC process, however, should not be

protracted by debate and decisiveness over minimal differences in pricing for Cobalt and Linac based systems. It is far more important to view these technologies from a global perspective and work to ensure that overall hospitals receive appropriate reimbursement for all services related to stereotactic radiosurgery.

In closing, I appreciate ASTRO's involvement in the CPT process and please feel free to contact me at (216) 444-5576 if you have any questions or if I can provide any additional information.

Sincerely,

A handwritten signature in black ink, appearing to read "Roger M. Macklis", with a horizontal line extending to the right.

Roger M. Macklis, M.D.

RM/pm

310

CMS-1501-P-266

1502 FFS

Submitter : Dr. Anne Kolker
Organization : Memorial Sloan Kettering Hospital and Cancer Center
Category : Physician

Date: 09/08/2005

Issue Areas/Comments

GENERAL

GENERAL

Proposed changes are detrimental to the teaching of Anesthesia residents

CMS-1501-P-266-Attach-1.WPD

CMS-1501-P-266-Attach-2.WPD

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P/TEACHING ANESTHESIOLOGISTS
P.O. Box 8017
Baltimore, MD 21244-8017

Dear Dr. McClellan:

I am writing as an anesthesiologist at Memorial Sloan Kettering Hospital and Cancer Center to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.

Medicare's discriminatory payment arrangement, which applies only to anesthesiology teaching programs, has had a serious detrimental impact on the ability of programs to retain skilled faculty and to train the new anesthesiologists necessary to help alleviate the widely-acknowledged shortage of anesthesia providers -- a shortage that will be exacerbated in coming years by the aging of the baby boom generation and their need for surgical services.

Under current Medicare regulations, teaching surgeons and even internists are permitted to work with residents on overlapping cases and receive full payment so long as the teacher is present for critical or key portions of the procedure. Teaching surgeons may bill Medicare for full reimbursement for each of the two procedures in which he or she is involved. An internist may supervise residents in four overlapping office visits and collect 100% of the fee when certain requirements are met.

Teaching anesthesiologists are also permitted to work with residents on overlapping cases so long as they are present for critical or key portions of the procedure. However, unlike teaching surgeons and internists, since 1995 the teaching anesthesiologists who work with residents on overlapping cases face a discriminatory payment penalty for each case. The Medicare payment for each case is reduced 50%. This penalty is not fair, and it is not reasonable.

Correcting this inequity will go a long way toward assuring the application of Medicare's teaching payment rules consistently across medical specialties and toward assuring that anesthesiology teaching is reimbursed on par with other teaching physicians.

Please end the anesthesiology teaching payment penalty.

Anne C. Kolker M.D.

--

Memorial Sloan Kettering Hospital and Cancer Center
1275 York Ave
New York, NY 10021
Phone: 1-212-639 6840

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P/TEACHING ANESTHESIOLOGISTS
P.O. Box 8017
Baltimore, MD 21244-8017

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Correcting this inequity will go a long way toward assuring the application of Medicare's teaching payment rules consistently across medical specialties and toward assuring that anesthesiology teaching is reimbursed on par with other teaching physicians.

Please end the anesthesiology teaching payment penalty.

Anne C. Kolker M.D.

--
Memorial Sloan Kettering Hospital and Cancer Center
1275 York Ave
New York, NY 10021
Phone: 1-212-639 6840

CMS-1502

311

Submitter : Dr. Jerry Cohen

Date: 08/24/2005

Organization : Dr. Jerry Cohen

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services

Attn: CMS-1502-P/TEACHING ANESTHESIOLOGISTS

P.O. Box 8017

Baltimore, MD 21244-8017

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Correcting this inequity will go a long way toward assuring the application of Medicare's teaching payment rules consistently across medical specialties and toward assuring that anesthesiology teaching is reimbursed on par with other teaching physicians.

Please end the anesthesiology teaching payment penalty.

Jerry A. Cohen

2358 NW 14 Pl, Gainesville, FL 32605

Submitter : tim washowich
Organization : tim washowich
Category : Physician

Date: 08/24/2005

Issue Areas/Comments

GENERAL

GENERAL

GPCIs

I am very concerned with the inequities of Medicare reimbursement rate for Santa Cruz County physicians out in California. The county is classified as a rural based on a 1960's decision. This situation clearly is not the case, as Santa Cruz County is now one of the most expensive counties in the country to live. We face a strong possibility of adequate health care availability as young doctors are not able to move into the county due to the high cost of living, with relative lower reimbursement rates compared to surrounding less expensive counties. I URGE the county be reclassified immediately, or an increase in reimbursement rates be made ASAP. This has been ignored for way too long. Making reimbursement rates based on a 40 year old decision is appalling to say the least. Please help the county be able to recruit and retain the young physicians needed to take care of the over 32,000 eligible citizens there.

CM 1502-P.

3/3

Submitter :

Date: 08/25/2005

Organization :

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

I am a patient who suffers from cardiovascular disease and am grateful that my current physician has purchased a device (BioZ) to help manage my disease. It has been brought to my attention that Medicare is proposing to reduce (the amount paid to physicians for this service, Thoracic Electrical Bioimpedance as well as many of services. My physician is questioning whether he can continue to perform this service if the payment changes. I strongly encourage you to reconsider this reduction. I can attest to how valuable this test is.

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September 6, 2005

SEP 12 2005

GPCIs
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1052-P
PO Box 8017
Baltimore, MD 21244-8017

To Whom It May Concern:

This letter is to draw your attention to the serious problem with Medicare compensation for the doctors of Sonoma County, CA.

Among cities with a population of 100,000 or more, our County seat, Santa Rosa, is sixth in the United States for the percentage of people 85 years and older. Seniors (60 and older) represent 16.6% of total population of Sonoma County with a projected rate of change of 196% from the year 2000 to 2020. And amid that growth in the elder population, Sonoma County has the lowest Medicare reimbursement rate in California.

In July 2005, six out of ten Sonoma County doctors were NOT accepting new Medicare patients and many physicians are leaving our County to practice where reimbursement is more favorable.

In June of 2005 I had knee surgery to correct a torn meniscus which followed a fall and was extremely painful. The surgery lasted for one hour and my orthopedic surgeon billed Medicare \$4,005.00. HE WAS PAID \$524.38, an amount so pitifully small as to be considered an insult; this, for a man who trained for eleven years and had responsibility for my life and mobility during this surgery.

The proposed Medicare increase in compensation for Sonoma County, CA of 8% is desperately needed. I sincerely hope you will take action now to alleviate this problem.

Sincerely,



Beth Barberis
6279 Meadowbreeze Ct.
Santa Rosa, CA 95409

315

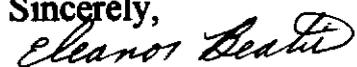
SEP 12 2005

September 6, 2005
6741 Wintergreen Ct.
Santa Rosa, Ca. 95409

To whom it may concern,

I am asking Medicare to correct reimbursement in Sonoma County, NOW!

Sincerely,



Eleanor Beatie

3/6

SEP 12 2005

September 7, 2005

Sonoma County is home to a lot of seniors as well as a lot of poor people of all ages. We need to have the reimbursement to Sonoma County corrected NOW!!!!!!! I am a senior and a concerned citizen regarding this problem which is long ongoing. Some of us don't drive and we need to have proper reimbursement to attract medical personnel to our area.


Terry Borhlke



ROBERT LEWON, 

SEP 12 2005

317

SEP 12 2005

11421 Barnett Valley Road
Sebastopol, Calif. 95472
(707) 823-7811
(707) 823-7990 FAX

Medicare -

We are writing in support of the plan to correct (raise) the reimbursement rates for Sonoma County, California.

We have watched the health care available in Sonoma County deteriorate substantially over the last several years. One of the main reasons is the low Medicare reimbursement rate.

Please correct the Medicare reimbursement in Sonoma County, California.

Thank you

Robert + Elaine Lewon

318

SEP 12 2005

Sept. 6, 2005

Centers For Medicare & Medicaid Services
Dept. Of Health & Human Services
Attn: CMS-1052-P
Baltimore, MD 21244-8017

Subj: GPCIs

Dear Government Officials:

I am a senior citizen on medicare in Rohnert Park, CA. in the county of Sonoma. There have been an alarming number of medical providers in this area who have either gone bankrupt or are close to it. Simply put, they have not had sufficient reimbursement from medicare for them to survive. How would you like to provide an important service as medical care and yet not be paid adequately for it? I think not. We seniors are finding fewer and fewer medical providers available to us as a result of this terrible situation.

To correct this injustice you must approve the reimbursement rate by 8 percent as has been proposed recently. Sonoma County is not a "rural" county by any stretch of the imagination. Your own figures tell you that. We plead with you to right this disparity and to give us the peace of mind we deserve in our old age. Thank you.

Sincerely,

Eileen V. Perry



319

SEP 12 2005

5555 Montgomery Dr. # F-102
Santa Rosa, CA 95409
September 7, 2005-8816

Medicare Services
Baltimore, MD 21244-8017

Please support the 8% increase in Medicare payments in Sonoma County, California.

Sonoma County has the lowest Medicare reimbursement rate of any county in the state and yet it is projected that between 2000 and 2020 the rate of older citizens will reach 19.6% of the population. At present it is 16.6%.

Many doctors are leaving Sonoma County where Medicare reimbursements are higher.

Do support the new rule that will increase the rate of reimbursement by 8%.

Sincerely,
(Mrs.) Evarista Mickelson

320

SEP 12 2005

ALLERTON & NINA BLAKE

8515 OAKMONT DRIVE, SANTA ROSA, CA 95409

September 6, 2005

GPCIs
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1052-P
P.O. Box 8017
Baltimore, MD 21244-8017

Re: Sonoma County medical reimbursement

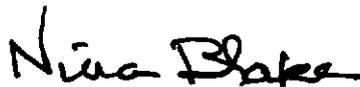
We are writing in support of the Medicare proposal to increase the reimbursement rate for Sonoma County by 8%. We have a large senior population in the county, and medical costs have risen much faster than in other areas. Many primary care physicians do not accept new Medicare patients because they cannot afford the cost, given the inadequate rate of reimbursement. Even worse, many physicians have left the county because of this inequity, and several medical groups have gone bankrupt, along with a major local health plan.

The proposal will help stabilize our medical community by bring Sonoma County back in line with current Medicare reimbursement standards. We urge you to enact this proposal as soon as possible to properly compensate our physicians and to help our county provide access to health care for all patients.

Sincerely,



Allerton Blake



Nina Blake

SEP 12 2005

September 06, 2005

Center for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1502-P
PO Box 8017
Baltimore, MD 21244-8017

RE: GPCIs

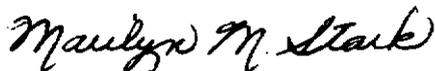
I am writing in support of the proposal by Medicare to increase the reimbursement rate for Sonoma County Physicians by 8%.

This increase is critical to maintaining quality medical care for seniors. Many local physicians are leaving the county to practice where reimbursement is more equitable. Several physicians in the county are NOT accepting new Medicare patients. Medical costs in Sonoma County have risen much faster than in other areas and are, on average, 8% higher than similar counties.

I believe that Medicare's proposal to change Sonoma County's payment locality is vital to the medical community, as well as, the many seniors it serves.

I appreciate the opportunity to comment on this important matter.

Sincerely,



Marilyn M. Stark
2521 Tamarisk Drive
Santa Rosa, CA 95405

Cc: Two copies attached



322

SEP 12 2005

SECRETARY OF STATE
BRUCE McPHERSON
STATE OF CALIFORNIA

August 31, 2005

Center for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P
Post Office Box 8017
Baltimore, MD 21244-8017

RE: GPCIs

To Whom It May Concern:

As a fourth generation Santa Cruz native, I strongly support the proposed revision to the physician payment localities in California that you published in the reference rule.

You are to be commended for addressing an important issue for physicians and Medicare beneficiaries in the San Francisco Bay Area. You have addressed the two most problematic counties in the state, and you have made an important change that will go a long way to ensuring access to care for health care services in our county.

I understand this also to be a fundamental issue of fairness. Neighboring counties to Santa Cruz and Sonoma Counties have some of the highest payment levels for physician services in the nation. The adjustment that you propose appropriately addresses the current inequitable payment problem.

CMS acknowledges that they have the responsibility to manage physician payment localities. I understand that there have been no revisions to the localities since 1996. You have selected the most important area in our state to begin to correct this problem.

Sincerely,

A handwritten signature in black ink that reads "Bruce McPherson".

BRUCE McPHERSON
Secretary of State

323
SEP 12 2005



Health Sciences Center

SCHOOL OF MEDICINE IN SHREVEPORT

Department of Anesthesiology

School of Medicine in Shreveport
School of Allied Health Professions
School of Graduate Studies

September 1, 2005

Centers for Medicare and Medicaid Services

Department of Health and Human Services

Attn: CMS-1502-P

P.O. Box 8017

Baltimore, MD 21244-8017

RE: TEACHING ANESTHESIOLOGISTS

CMS' proposed changes to the Medicare Fee Schedule for 2006 released on August 1, 2005, do not include a correction of the discriminatory policy of paying teaching anesthesiologists only 50% of the fee for each of two concurrent resident cases. This is unwise, unfair, and unsustainable.

Our teaching program at LSU Health Sciences Center in Shreveport finished this last fiscal year over \$300,000 in the red. Our surgeons supervise residents in two overlapping operations and collect 100% of the fee for each case; our internists supervise residents in four overlapping visits and collect 100% of the fee for each. However, our teaching anesthesiologists collect 50% of the Medicare fee when supervising two residents. This problem is augmented, of course, by the decreased conversion factor for anesthesiology compared to the other specialties.

Anesthesiology is the only branch of modern medicine that was developed in the United States. We do not want this great legacy to wither away and die. Last year, three of our training programs closed. We should nourish our training programs, not destroy them.

Yours truly,

A handwritten signature in black ink, appearing to read "Randall C. Cork".

Randall C. Cork, M.D., Ph.D.

Professor and Chair

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P/TEACHING ANESTHESIOLOGISTS
P.O. Box 8017
Baltimore, MD 21244-8017

08/31/2005

Dear Dr. McClellan:

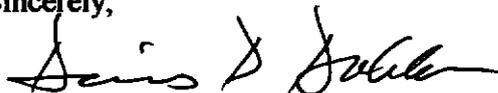
I am writing as an anesthesiologist at The University of Alabama at Birmingham to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare policy for payment of anesthesiology teaching.

The current payment arrangement is unfair and discriminatory and has a detrimental impact on retention of faculty to train the new anesthesiologists during the widely acknowledged shortage of anesthesia providers.

Under current Medicare regulations, teaching surgeons staffing two cases and teaching internists running four clinic rooms receive full payment as long as the teacher is present for critical or key portions of the procedure. Teaching anesthesiologists are also permitted to work with residents on overlapping cases so long as they are present for critical or key portions of the procedure. Since 1995 the teaching anesthesiologists who work with residents on overlapping cases are penalized 50% for each case.

Please stop the anesthesiology teaching payment penalty that discriminates against us.

Sincerely,



Dennis D. Doblak, Ph.D., M.D.
Professor of Anesthesiology and
Biomedical Engineering
Director of Clinical Research



NORTHWEST
KIDNEY CENTERS

325

SEP 12 2005

September 2, 2005

TO: Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1502-P
PO Box 8017
Baltimore, MD 21244-8017

FROM: Joyce F. Jackson
President and CEO

RE: ESRD Composite Payment Rate Wage Index

Dialysis Facilities
Located In:

Auburn
Bellevue
First Hill
Lake City
Normandy Park
Northgate
Port Angeles
Renton
Seattle
Snoqualmie
Totem Lake
West Seattle

Dialysis Services
Also Provided In:

140 Homes
13 Hospitals

The Northwest Kidney Centers applauds the effort by CMS to address the outdated computation of the labor related share of the ESRD composite payment. We agree with your methodology for updating this rate.

In addition, the Northwest Kidney Centers agrees with the use of CBSA labor market areas and the methodology used to compute the ESRD Wage Index. We applaud the commitment to update the wage index on an annual basis as part of the overall ESRD payment update.

These changes are major steps toward updating the payment system for the ESRD program.

Thank you.

Since 1962...
*sustaining life,
inspiring hope.*

700 Broadway

Seattle, WA 98122

Ph: 206.292.2771

Fx: 206.860.5821

www.nwkidney.org

326

SEP 12 2005

Centers for Medicare and Medicaid Services
Dept. of Health and Human Services
Attention: CMS-1502-P
P.O. Box 8017
Baltimore, MD. 21244-8017

September 4, 2005

Re: GPCI

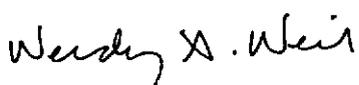
To Whom It May Concern:

My son is a severely disabled young adult who lacks the ability to write to you. Looking toward his future and my own, I am keenly aware of the fact that the excellent care we receive from our dedicated local physician is at risk. For years, I have followed media reports detailing the problems our local community faces with regard to under par Medicare reimbursement for local physicians.

I understand that a proposed rule will remove our county from the rest of California physician payment locality designation. Under this change, local physicians would receive payments from Medicare on par with other counties in the San Francisco Bay Area.

The cost of living here is exorbitant and if physicians cannot afford to live here, the local citizens face a health care emergency. Therefore, we greatly appreciate your attention to this vital issue. We wholeheartedly support the proposed changes that you have made.

Sincerely,



Wendy A. Weil
148 Crest Drive
La Selva Beach, Ca.
95076



BRIGHAM AND
WOMEN'S HOSPITAL



327
HARVARD
MEDICAL SCHOOL

75 Francis Street
Boston, Massachusetts 02115
Tel: 617.732.8218, Fax: 617.582.6131
Email: ddedrick@partners.org

Daniel F. Dedrick, M.D.
Assistant Professor of Anesthesia
Director of Residency Education, Program Director
Department of Anesthesiology, Perioperative
and Pain Medicine
Brigham and Women's Hospital

September 7, 2005

SEP 12 2005

Mark McClellan, M.D., Ph.D., Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P/TEACHING ANESTHESIOLOGISTS
P.O. Box 8017
Baltimore, MD 21244-8017

Dear Dr. McClellan:

I am writing both as a nationally recognized Program Director (one of the 2005 ACGME Parker J. Palmer "Courage to Teach" Award winners) and as a faculty anesthesiologist at Brigham and Women's Hospital, a Harvard teaching institution, to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.

In the current competitive health care environment, Medicare's discriminatory payment arrangement, which applies *only* to anesthesiology teaching programs, has had a serious detrimental impact on the ability of our Department to recruit and retain the skilled faculty needed to train the new anesthesiologists necessary to help alleviate the widely-acknowledged shortage of anesthesia providers, a shortage that will be exacerbated in coming years by both population growth and the aging of the baby boom generation and their need for surgical services.

Under current Medicare regulations, teaching surgeons and even internists are permitted to work with residents on overlapping cases and receive full payment so long as the teacher is present for critical or key portions of the procedure. Teaching surgeons may bill Medicare for **full reimbursement for each of two** procedures in which he or she is involved. An internist may supervise residents in **four** overlapping office visits and collect 100% of the fee when certain requirements are met.

Teaching anesthesiologists are also permitted to work with residents on overlapping cases so long as they are present for critical or key portions of the procedure. However, unlike teaching surgeons and internists, since 1995 the teaching anesthesiologists who work with residents on overlapping cases face a discriminatory payment penalty for each case. The Medicare payment for each case is **reduced** 50%. This penalty is not fair, and it is not reasonable.

Correcting this inequity will go a long way toward assuring the application of Medicare's teaching payment rules **consistently across medical specialties** and toward assuring that anesthesiology teaching is reimbursed **on par with other teaching physicians**.

Please end the anesthesiology teaching payment penalty. We deserve **equal protection under the law**, not discrimination based on medical specialty!

Sincerely,

A handwritten signature in cursive script, reading "Daniel F. Dedrick, MD". The signature is written in black ink and is positioned below the word "Sincerely,".

Daniel F. Dedrick, MD



ACADEMY OF MOLECULAR IMAGING

www.ami-imaging.org

ami@mednet.ucla.edu

September 7, 2005

The Honorable Mark McClellan
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
Room 445-G
200 Independence Avenue, S.W.
Washington, D.C. 20201

RECEIVED - CMS
2005 SEP -9 PM 3:09

Re: File Code CMS-1502-P

Proposed rule for the Medicare Program regarding
Revisions to Payment Policies Under the Physician
Fee Schedule for Calendar Year 2006 -- NUCLEAR
MEDICINE SERVICES

Dear Administrator McClellan:

The Academy of Molecular Imaging (AMI)¹ appreciates the opportunity to comment on the proposed Physician Fee Schedule rule, as published in the Federal Register on August 8, 2005 by the Centers for Medicare and Medicaid Services (CMS). AMI comments specifically on the provision relating to physician referrals for nuclear medicine services with which they have financial relationships. Under the proposed rule, CMS would reclassify nuclear medicine services as Designated Health Services (DHS), thereby bringing them within the category of services covered by the physician self-referral law. AMI believes that this change would significantly limit beneficiary access to nuclear medicine services. Of special concern is its potential impact on the availability of positron emission tomography (PET) scans, which constitute an important share of Medicare-covered nuclear imaging. AMI respectfully requests that this proposed change not be included in the final rule for two reasons. First, Congress did not intend for the physician self-referral law to apply to nuclear medicine services because it recognized, as has CMS, that nuclear medicine is a distinct medical specialty from radiology. Second, nuclear medicine services are not at risk for the kind of over-utilization that the physician self-referral rules are designed to prevent.

Box 951735
Los Angeles, CA
90095-1735
310.267.2614
Fax: 310.267.2617

President
Sanjiv Sam Gambhir, M.D., Ph.D.
Stanford School of Medicine

President-Elect
Johannes Czerny, M.D.
David Geffen School of
Medicine at UCLA

Secretary
Karthik Kuppasamy, Ph.D.
GE Healthcare

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Pfizer Global Research
and Development

Ronald Nutt, Ph.D.
CTI Molecular Imaging, Inc.

Michael E. Phelps, Ph.D.
David Geffen School of
Medicine at UCLA

Markus Schwaiblmair, M.D.
Technische Universität München

Barry A. Siegel, M.D.
Mallinckrodt Institute of Radiology
Washington University in St. Louis

Henry Van Brocklin, Ph.D.
Lawrence Berkeley
National Laboratory

Kurt Zinn, D.V.M., Ph.D.
University of Alabama
at Birmingham

Ex-Officio
Jorge R. Barrio, Ph.D.
David Geffen School of
Medicine at UCLA

Council Chairs
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University of Alabama
at Birmingham

Institute for Clinical PET:
Homer Macapinlac, M.D.
M.D. Anderson Cancer Center

Institute for Molecular
Technologies:
Ron Nutt, Ph.D.
CTI Molecular Imaging, Inc.

Society of Non Invasive
Imaging In Drug Development:
Timothy J. McCarthy, Ph.D.
Pfizer Global Research
and Development

Henry Van Brocklin, Ph.D.
Lawrence Berkeley
National Laboratory

¹ The AMI is a professional organization committed to advancing the field of molecular imaging. In addition to its annual conference, the AMI holds programs designed to educate clinicians, government agencies and the public about molecular imaging, and publishes a journal, *Molecular Imaging and Biology*.

However, in the event that CMS disagrees with AMI's recommendations and does reclassify nuclear medicine services as DHS, AMI requests that the final rule exempt from the prohibition on self-referrals physician ownership arrangements that have been formed in good-faith reliance on the existing regulations.

I. Nuclear Medicine Services are not DHS Under the Physician Self-Referral Statute

The statutory text, legislative history, and CMS's own long-standing interpretation of the physician self-referral law clearly support the exclusion of nuclear medicine from the definition of DHS. Congress specifically elected not to classify nuclear medicine services as DHS. Under Section 1877(h)(6) of the Social Security Act, DHS encompass only certain enumerated services, which do not include nuclear medicine. The statute specifically lists the following services:

*clinical laboratory services; physical therapy services; occupational therapy services; radiology services, including magnetic resonance imaging, computerized axial tomography, and ultrasound services; radiation therapy services and supplies; durable medical equipment and supplies; parenteral and enteral nutrients, equipment, and supplies; prosthetics, orthotics, and prosthetic devices and supplies; home health services; outpatient prescription drugs; and inpatient and outpatient hospital services.*²

The proposed rule acknowledges that the statute does not mention nuclear medicine. In order to bring nuclear medicine within the scope of the statutory limitations on physician self-referral, the proposed rule must therefore argue somehow that nuclear medicine is encompassed in one of the congressionally enumerated categories. CMS proposes to accomplish this by re-designating nuclear medicine procedures under what it calls "*radiology and certain other imaging services.*"³ However, this phrase is not included in the applicable statutory provision and is clearly beyond the scope of the statutory language.

Specifically, the words "*certain other imaging services*" do not even appear in Section 1877(h)(6). In fact, Congress has expressly rejected virtually identical statutory phrasing. The original provision included the extremely broad category "*radiology, and other diagnostic services*" as DHS in Section 1877(h)(6)(D) of the Omnibus Budget Reconciliation Act of 1993.⁴ The following year, however, in the Social Security Act Amendments of 1994, Congress narrowed that broad language by striking the phrase "*other diagnostic services,*" and replacing it with a far more precise description of the covered services. The new, narrowly drawn category of DHS consisted of "*radiology services, including magnetic resonance imaging, computerized axial tomography, and ultrasound services.*"⁵ This provision does not mention nuclear medicine or particular nuclear medicine technologies, such as PET.

The proposed rule now seeks to rely on language that Congress has previously rejected. If Congress had intended to broaden the scope of the statute to include nuclear medicine services it would have retained the earlier, broadly drawn category. Alternatively, Congress could have listed nuclear medicine services, such as PET, alongside of MRI, CT, and ultrasound. Instead, when Congress amended the statute, it affirmatively defined the scope of radiology services to omit nuclear medicine.

² 42 U.S.C. § 1395nn(h)(6) (2005).

³ 70 Fed. Reg. 151 (Aug. 8, 2005).

⁴ Public Law 103-66, Sec. 13,562 (Aug. 10, 1993).

⁵ Public Law 103-432, Sec. 152 (Oct. 31, 1994).

Moreover, this interpretation of Section 1877(h)(6)(D) conforms to CMS's own long-standing and well-considered view that nuclear medicine is not a radiology service for the purpose of the physician self-referral law. After carefully considering the statutory text and legislative record, CMS concluded in its January 4, 2001 final rule to "*exclude[] nuclear medicine [from DHS] because those services are not commonly considered to be radiology.*"⁶ It bears emphasis that this judgment was based on a specific factual finding with respect to the proper classification of nuclear medicine.

As will be discussed below, the proposed rule offers no evidence to support reversing the factual and regulatory conclusion that it reached less than five years ago. As the Supreme Court has observed, a "settled course of behavior embodies [an] agency's informed judgment that, by pursuing that course, it will carry out the policies committed to it by Congress." Because agencies and reviewing courts alike operate under "a presumption that those policies will be carried out best if the settled rule is adhered to," an agency that departs from such a rule "is obligated to supply a reasoned analysis for the change beyond that which may be required when an agency does not act in the first instance."⁷ The proposed rule does not satisfy this obligation. For CMS to reclassify nuclear medicine in the manner indicated would be to allow its preferred regulatory application to dictate its factual findings, rather than the reverse.

II. Nuclear Medicine Is a Distinct Medical Specialty from Radiology

Nuclear medicine services are clinically and technically distinct from the services that Congress enumerated when it defined the scope of "radiology services" in Section 1877(h)(6)(D). The American Board of Nuclear Medicine (ABNM), the primary certifying organization for the practice of nuclear medicine in the United States, defines nuclear medicine as "*the medical specialty that employs radionuclides to evaluate metabolic, physiologic and pathologic conditions of the body for the purposes of diagnosis, therapy and research.*"⁸ In a typical procedure, a physician trained as a nuclear medicine specialist supervises the administration of a radioactive material into a patient. The subsequent distribution of this material within the body is then determined by a special device that detects the radioactivity coming from the patient. The nuclear medicine physician makes a diagnosis based on that distribution.⁹

The introduction of radiolabeled, biologically active compounds into patients distinguishes nuclear medicine from radiology. Although radiologists sometimes do administer "contrast agents," such as barium sulfate or iodine (X-ray), or gadolinium (MRI), these agents are biologically inert, and their function is entirely different from that of radioisotopes in a nuclear

⁶ 66 Fed. Reg. 927 (Jan. 4, 2001). More recently, CMS confirmed its practice of construing the scope of "radiology services" narrowly with respect to other (non-nuclear) procedures, finding that "angiographies, angiograms, cardiac catheterizations, and endoscopies . . . are not fundamentally radiological in nature because they do not involve an imaging service that is described in 1877(h)(6)(D) of the Act." 69 Fed. Reg. 16,104 (Mar. 26, 2004).

⁷ *Motor Vehicle Manufacturers Ass'n of the U.S., Inc. v. State Farm Mutual Automobile Ins. Co.*, 463 U.S. 29, 42-43 (1983) (quoting *Atchison, Topeka & Santa Fe Ry. v. Wichita Bd. of Trade*, 412 U.S. 800, 807 (1973) (internal citations omitted)).

⁸ <http://www.abnm.org/index.html> (accessed June 28, 2005).

⁹ See, e.g., <http://www.radiochemistry.org/nuclearmedicine/definition.htm>. Through PET, for example, the molecular errors that cause disease can be accurately identified and understood in terms of the specific nature of the disease. This separates PET from conventional anatomic imaging modalities such as X-ray films, CT and MRI. By assisting physicians in the diagnosis and management of tumors, cardiac disorders and neurological disorders, PET can eliminate unnecessary surgeries, reduce the number of diagnostic procedures, and otherwise help physicians to determine the best, most effective mode of treatment for a patient.

medicine procedure. Additionally, some of the procedures performed in nuclear medicine are for therapeutic purposes, and specialized training, such as that obtained in programs leading to certification by the ABNM, is a prerequisite for clinically appropriate use.

The proposed rule provides little in the way of independent authority to controvert its earlier position that nuclear medicine services "are not commonly considered to be radiology." The proposed rule relies, first, on an excerpt from Dorland's Illustrated Medical Dictionary and a statement by the Society for Nuclear Medicine, confirming that nuclear medicine procedures involve the introduction into the body of tracers that emit small amounts of radiation. The proposed rule appears to imply that because nuclear medicine employs radioactive material, logically it must be a subspecialty of diagnostic radiology. This implication is not warranted. Radioactive materials are used in many other areas of clinical practice--for example, the performance of radioimmunoassays and irradiation of blood products. Importantly, these procedures are not considered radiological services merely because they involve radioactive material.¹⁰

The proposed rule also relies on a letter from the American College of Radiology (ACR), claiming that nuclear medicine is "a part of the specialty of radiology" and noting that the American Board of Radiology's (ABR) process of certifying diagnostic radiologists includes examination in nuclear medicine. This position is directly contradicted by the American Board of Medical Specialties (ABMS), the body that officially sanctions all medical residency training programs in the United States. It is physicians trained in ABMS-approved programs, rather than the ABR, that define the specialty of nuclear medicine. According to the ABMS, Nuclear Medicine and Radiology each possess "primary" (that is, fundamental and independent) board status as medical specialties. Nuclear Medicine, like Radiology, is one of only 26 distinct medical disciplines subject to Primary Board Certification. Services such as CT and MRI, by contrast, have "affiliate" status, and are among the many subspecialty groups within radiology. Moreover, the ABMS oversees separate specialty training programs in both diagnostic radiology and nuclear medicine. Although some nuclear medicine training is incorporated into the diagnostic radiology training program, and the ABR does include questions on nuclear medicine in its certification examination, physicians become eligible to take the ABNM examination only after successfully completing a nuclear medicine residency program.¹¹

The proposed rule further attempts to bolster its assertion that nuclear medicine is a subcategory of radiology by citing the fact that the Social Security Act "places nuclear medicine in the same category as diagnostic radiology for coverage and payment purposes." CMS points to Section 1833(t), providing payment for "outpatient hospital radiology services (including diagnostic and therapeutic radiology, nuclear medicine, CAT scan procedures, magnetic resonance imaging, and ultrasound and other imaging services, but excluding mammography)," as described in Section 1833(a)(2)(E)(i). CMS interprets this provision to mean that Congress considers nuclear medicine to be a subcategory of radiology services. In fact, Section 1833(t) is strictly a payment provision, and refers to the grouping of technologies in Section 1833(a)(2)(E)(i) exclusively for

¹⁰ In addition, hospitals and clinics frequently house nuclear medicine departments that are separate from their radiology departments, whereas ultrasound, MRI and CT are virtually always performed in radiology departments.

¹¹ In addition, for a physician to be eligible for a dual certification in nuclear medicine and radiology under the ABNM program, she must first obtain separate approval for her proposed training program from both the ABNM and the ABR. After completing her training, she must then pass a certifying examination in radiology and a certifying examination in nuclear medicine, each administered by its respective certifying board.

the administrative purposes of providing for Medicare reimbursement.¹² Further, 1833(a)(2)(E) predates the enactment Section 1877, limiting physician self-referrals, by several years. If Congress had considered Section 1833(a)(2)(E) an authoritative description of the scope of radiology services, it could have imported that language directly into Section 1877(h)(6) when it amended the self-referral law in 1993 and 1994. The fact that Congress did not do so lends further support to the position that Congress has never considered nuclear medicine a subcategory of radiology for the purpose of Section 1877(h)(6).

Finally, the proposed rule suggests that the fact that nuclear medicine and radiological services are both paid under Section 1861(s)(3) evidences their clinical similarity. Again, the proposed rule supplies no basis for concluding that their common classification in this narrow context bears on the question of whether nuclear medicine is a subspecialty of radiology, or whether that classification represents anything more than administrative convenience. In fact, Section 1861(s)(3) applies to all diagnostic tests regardless of their clinical properties, and includes not only MRI, CT, and PET, but also diagnostic clinical laboratory tests.¹³

III. Nuclear Medicine Services are not Subject to Over-Utilization

The proposed rule offers no evidence that nuclear medicine services are abused or over-utilized. CMS maintains that any lingering doubt about whether “nuclear medicine services are radiology...within the meaning of section 1877(h)(6)” should be resolved in favor of the proposed rule, because such services “pose the same risk of abuse that the Congress intended to eliminate for other types of radiology, imaging, and radiation therapy services and supplies.”¹⁴

The empirical support cited for this claim is particularly misleading and unreliable. The proposed rule relies on a number of studies of diagnostic imaging, but none that have reviewed the utilization of any nuclear medicine service, including PET. Although the proposed rule acknowledges that the principal study on which it relies excluded nuclear imaging, it insists that there is “[no] basis for assuming that physician behavior would be different for nuclear imaging than it is for other imaging services.” Imaging services encompass an extremely wide variety of technologies and clinical uses, and it is not easy to extrapolate data from one service and apply it to another. Unlike most radiology services, nuclear medicine imaging introduces radioactive material directly into the body. This is an important factor in limiting clinical use of nuclear medicine imaging to medically useful and appropriate circumstances. Second, as is discussed below, limitations on Medicare coverage for PET likewise significantly constrain its use. Unlike CT and MRI, PET is subject to numerous national coverage determinations limiting coverage to certain tumor types and indications.¹⁵

¹² Under CMS’s reading of Section 1833(t), Congress’ inclusion of the catch-all category of “other imaging services” in the parenthesis following “radiology services” would make *any* imaging service a subcategory of radiology.

¹³ The Section covers “diagnostic X-ray tests (including tests under the supervision of a physician, furnished in a place of residence used as the patient’s home, if the performance of such tests meets such conditions relating to health and safety as the Secretary may find necessary and including diagnostic mammography if conducted by a facility that has a certificate (or provisional certificate) issued under Section 354 of the Public Health Service Act), diagnostic laboratory tests, and other diagnostic tests.”

¹⁴ 70 Fed. Reg. 151 (Aug. 8, 2005).

¹⁵ See, e.g., Medicare National Coverage Determinations Manual § 220.6 (Rev 35, May 6, 2005).

The proposed rule also relies on the fact that since the publication of the Phase I final rule excluding nuclear medicine services from DHS, "many more nuclear medicine procedures have been performed in physician offices or in physician-owned freestanding facilities." The proposed rule reports that while physician services in general increased by 22 percent between 1999 and 2003, imaging services increased by 45 percent, and nuclear medicine services increased by 85 percent. The implication appears to be that the absence of self-referral restrictions on nuclear medicine services has made such services increasingly, perhaps even especially, subject to over-utilization. This implication is unwarranted. Two particular considerations account for the relative growth of nuclear imaging services. First, nuclear medicine imaging still represents only a very small fraction of all diagnostic imaging. For this reason, even modest numerical growth can appear dramatic when it is presented in the form of a percentage increase. Despite PET's recent increase in utilization the total number of PET scans performed is dwarfed by the number of other imaging procedures performed, such as MRI and CT. In 2004, PET still accounted for less than one percent of Medicare reimbursement for diagnostic imaging.

Second, as the proposed rule notes, Medicare coverage of PET scans has expanded since December 2001, a change that reflects CMS's recognition of PET's utility in diagnosing and treating an increasing variety of cancers. In fact, expansion of coverage by Medicare, and not inappropriate referral, is likely the most important factor in increased utilization of PET scans. Unlike Medicare coverage of MRI and CT, coverage of PET initially was extremely limited and only applied to a handful of cancer indications and qualifying uses, such as staging. Although CMS has gradually extended PET coverage for cancer over the past four years, at present Medicare still only covers the 8 to 10 leading tumor types. Coverage also remains limited to certain functions, such as diagnosis and staging, and does not apply to the monitoring of therapeutic response. Further, many common cancers, such as prostate, ovarian, and testicular remain ineligible, while others, such as breast and cervical, are covered but reimbursement is confined to clinically appropriate referrals. CMS has proposed to expand coverage to all cancers, but the decision has not yet been implemented. These tight coverage policies function as an intrinsic check on the risk of exactly the kinds of over-utilization and abuse that the self-referral prohibitions are designed to prevent. In summary, the very specific criteria enumerated in the expansion of Medicare coverage for PET scans created a scenario where the increase in utilization, sanctioned by Medicare, is highly unlikely to include clinically unnecessary or inappropriate PET scans.

As part of its proposed expansion of PET coverage, CMS is working with AMI to establish a national data registry, which will be one of the first new coverage policies instituted under Coverage with Evidence Development (CED). Any new coverage of PET would require the referring physician to submit a case report form to a data registry. The data registry will provide CMS with accurate information on how PET impacts patient management and improves health outcomes. Such information will afford CMS an invaluable tool with which to evaluate PET's utility in improving the management of oncology patients.

The proposed rule further states that the "risk of abuse and anti-competitiveness" that exists with physician self-referrals in general "is exacerbated by the greater affordability of nuclear medicine equipment."¹⁶ This statement misapprehends both the importance of many physician-owned nuclear medicine services to patient access, and the nature of most current physician ownership

¹⁶ 70 Fed. Reg. 151 (Aug. 8, 2005).

interests. Because the equipment in physician-owned PET centers is expensive, typically an individual physician owns only a small percentage interest, and, as a result, has a very modest stake in the center's profitability. These small stakeholders do not have a substantial incentive to over-utilize PET scans. By including nuclear medicine as a DHS, however, the proposed rule would encourage many individual and group physician-owners to acquire expensive PET equipment to operate in their own private offices, under the in-office ancillary service exception to the self-referral rule. The proposed rule would thus result in many physicians acquiring a *more* substantial ownership interest in PET scanners than they now possess, and for that reason could exacerbate, rather than mitigate, the potential for over-utilization.

IV. Should CMS Reclassify Nuclear Medicine Services as DHS, Existing Physician Ownership Interests Should be Exempted from the Prohibition on Self-Referrals

If CMS does reclassify nuclear medicine as a DHS, contrary to the statutory language, it should take strong measures to protect current physician-stakeholders. CMS rightly acknowledges that the guidance it offered in the Phase I final rule has "*encouraged physician investment in nuclear medicine equipment and ventures, particularly PET scanners, which are very expensive and often require a substantial financial investment on the part of physician-owners.*"¹⁷ Many physicians have entered into ownership arrangements in good-faith reliance on the existing regulations, not least CMS's express exclusion of nuclear imaging from DHS. Accordingly, the proposed rule recognizes that it may be necessary to extend special consideration to physicians who have pre-existing ownership interests. The rule specifically requests comments on whether to delay the new rule's effective date or to "grandfather" certain arrangements. As set out below, AMI respectfully requests that CMS minimize the impact of any change to the physician self-referral requirements on both beneficiary access and physician-investors by exempting existing physician-owned nuclear medicine services from reclassification as DHS.

When Congress established, in the Medicare Modernization Act, an 18-month moratorium on physician self-referrals to specialty hospitals, it concluded that as a matter of basic fairness it would be inappropriate to apply the new prohibition to physicians who had already made substantial investments in such hospitals.¹⁸ Accordingly, Congress provided for the grandfathering of existing facilities and those under development as of the date that the specialty hospital bill was passed by both houses. The case for grandfathering is even more compelling with respect to nuclear medicine services, because physicians have relied on CMS's express declaration that nuclear medicine is not a subspecialty of radiology. AMI urges that a similar grandfathering exemption be adopted for physician-owned nuclear medicine services, and proposes the following language:

Any nuclear medicine service provided at a facility in operation or under development on the effective date of the final rule, and for which

- (i) the number of physician investors has not increased since that date;

¹⁷ 70 Fed. Reg. 151 (Aug. 8, 2005).

¹⁸ See CMS Transmittal No. 62, March 19, 2004, available at http://www.cms.hhs.gov/manuals/pm_trans/R62OTN.pdf.

(ii) the specialized services furnished by the facility have not expanded beyond imaging since that date; and

(iii) there has not been a substantial increase in the capacity of the facility due to the addition of capital equipment, except for capital equipment acquired for the purpose of replacing or upgrading existing equipment, is not a Designated Health Service.

Conclusion

AMI believes that compelling evidence of congressional intent, the clinical distinctiveness of nuclear medicine from radiology, strong inherent checks against over-utilization, and the specific structure of physician ownership interests all counsel strongly against subjecting nuclear medicine services to the prohibition against physician self-referral. For these reasons, AMI respectfully requests that CMS maintain its present policy that nuclear medicine services are not DHS. AMI would welcome the opportunity to meet with agency staff during the comment period in order to discuss these issues in more detail.

Very truly yours,

R. Edward Coleman

R. Ed Coleman, M.D.



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SEP 14 2005

**CENTRAL
FIRE PROTECTION DISTRICT**
of Santa Cruz County

930 17th Avenue, Santa Cruz, CA 95062-4125
phone (831) 479-6842 fax (831) 479-6848

www.centralfpd.com

September 8, 2005

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1502-P
P.O. Box 8017
Baltimore, MD 21244-8017

Re: File Code CMS1502-P

Issue Identifier: GPCI's/Payment Localities

Dear Sir:

I am writing on behalf of Central Fire Protection District of Santa Cruz County to strongly support your proposed revision to physician payment localities in California, recently published in the reference rule. Central Fire District is writing to express our concern about the viability of the health care system which serves our residents. The great difference between the cost of medical practice in Santa Cruz County as measured by BAF cost values and the low rate of reimbursement due to being assigned to Locality 99 has made recruitment and retention of physicians willing to serve Medicare beneficiaries very difficult.

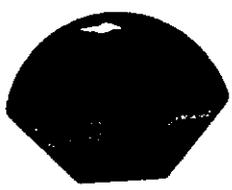
We were pleased to see that your proposed rule would alleviate this problem by removing Santa Cruz and Sonoma Counties from Locality 99 and placing them into unique localities. We laud your efforts to rectify this long-standing inequity. Your proposal will be of great help in ensuring access to necessary health care services. We believe the proposed rule to be fair. Neighboring counties to Santa Cruz and Sonoma have some of the highest payment levels for physicians in the nation. The adjustment you propose appropriately addresses this payment imbalance. This revision would bring you closer to your goal of reimbursing physicians based on the cost of practice in their locality.

Sincerely,

Bruce Clark, Fire Chief of Central Fire District

Serving The Communities of Capitola, Live Oak, and Soquel

330



Aptos/La Selva Fire Protection District
6934 Soquel Drive • Aptos, CA 95003
Phone # 831-685-6690 • Fax # 831-685-6699

September 6, 2005

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1502-P
P. O. Box 8017
Baltimore, MD 21244-8017

Re. File Code CMS1502-P

Issue Identifier: GPCI's / Payment Localities

Dear Sirs:

I am writing on behalf of the Aptos/La Selva Fire District to strongly support your proposed revision to physician payment localities in California recently published in the referenced rule. The Fire Chiefs of Santa Cruz County have written previously to express our concern about the viability of the health care system which serves our residents. The great difference between the cost of medical practice in Santa Cruz County as measured by GAF cost values and the low rate of reimbursement due to being assigned to Locality 99 has made recruitment and retention of physicians willing to serve Medicare beneficiaries very difficult.

We were pleased to see that your proposed rule would alleviate this problem by removing Santa Cruz and Sonoma Counties from Locality 99 and placing them into unique localities. We laud your efforts to rectify this long-standing inequity. Your proposal will be of great help in ensuring access to necessary health care services. The proposed rule is fair. Neighboring counties to Santa Cruz and Sonoma have some of the highest payment levels for physicians in the nation. The adjustment you propose appropriately addresses this payment imbalance. This revision would bring you closer to your goal of reimbursing physicians based on the cost of practice in their locality.

Sincerely,

Tom Crosser
Fire Chief

Cc: Dr. Wolfe

September 2, 2005

Mark B. McClellan, M.D., Ph.D.
Centers for Medicare & Medicaid Services
Department of Health and Human Services
CMS-1502-P
P.O. Box 8017
Baltimore, MD 21244-8017

Re: CMS-1502-P

Dear Dr. McClellan:

I have been a practicing audiologist for 32 years, over 20 of them as the owner of a multi-office private practice. I am concerned that the Centers for Medicare & Medicaid Services' (CMS) proposed Medicare Physician Fee Schedule will reduce Medicare reimbursement for audiology services by as much as 21% over a four-year period beginning in 2006.

As the lifespan of America's seniors increases, a greater need for audiology services is developing. For Medicare patients, the benefits of having qualified and licensed audiologists who are trained to evaluate and care for them are immeasurable. If a fee schedule with significant reductions goes into effect, audiologists may not be able to offer services to Medicare beneficiaries. In the interest of these seniors, CMS is obligated to develop an equitable reimbursement rate for these services.

Adequate and fair reimbursement rates for audiology services are essential to cover the expenses that audiologists incur in performing hearing and vestibular services for Medicare beneficiaries. *No other specialty* is as dramatically affected by the proposed elimination of the non-physician work pool (NPWP) and the new methodology to calculate the practice expense relative value units.

I request that you work with the audiology community and the American Academy of Audiology to address the negative impact of the elimination of the non-physician work pool. We all want to ensure that Medicare beneficiaries have access to these vital services.

Best regards,



Gail Gudmundsen, Au.D.

Audiologist

Immediate Past Chair, Licensure Board, Illinois Department of Professional Regulation
Former member-at-large, Board of Directors, American Academy of Audiology

cc: Mr. Herb Kuhn, Director, Center for Medicare Management



Mrs. Phyllis L. Thevenin
528 6th Ave.
Santa Cruz, CA 95062

Dear Medi-care People. 332

SFP 14 2005
I'm 72 yrs old. I'm grate-
ful for my dedicated MDs
who work hard to help us
all stay well. I'm happy
that they will - Jan 1, '06 be
receiving ^{the increased} payments for
their services that they deserve.

We have a shortage of
doctors in Santa Cruz, Ca.
(formerly in Area 99) Thank
you for including us
your San Francisco Bay
Area

Maybe soon we'll be
able to see new doctors
to replace some who have
delayed retirement.

Thank You,
Phyllis Thevenin

333

9-8-05

Centers for Medicare & Medicaid Services
HHS

SEP 14 2005

Attn: CMS-1507-P

To Whom it May Concern -

I urge you to accept
the proposed rule to reclassify
Santa Cruz County similar to
other counties in the SF Bay Area.

Our county has a very high
cost of living & our doctors
should be reimbursed accordingly.

Thank you

Joan Harrington-Trenbeth

Joan Harrington-Trenbeth
275 Beach Pines Dr.
Aptos, CA
95003-4703

4955 Warm Springs Rd.
Glen Ellen, CA 95442
6 September 2005

SEP 14 2005

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-1052-P
P.O. Box 8017
Baltimore, MD 21244-8017

re:Medicare reimbursement

Dear Sir:

Residents and doctors in Sonoma County, California, have long wondered why Medicare reimbursement designates this area as "rural," though part of it is agricultural (mostly vineyards). But it is also one of the most expensive counties in the nation in which to buy housing. People are literally moving away because they cannot afford to live here, and 60% of doctors have stopped accepting Medicare, although the retired population is very high. We understand thrift, but this kind of thrift on the part of the government is unfair to everyone involved and forces many to seek care at more expensive emergency facilities.

Please listen to our local representatives Woolsey and Thompson and grant full urban reimbursement.

Sincerely,

Patricia Spicer

William L Spicer MD

Patricia Spicer
William L. Spicer, M.D.

335

**RUSSELL D. SAUCER
779 Dizzy Gillespie Way
Windsor, CA 95492**

September 6, 2005

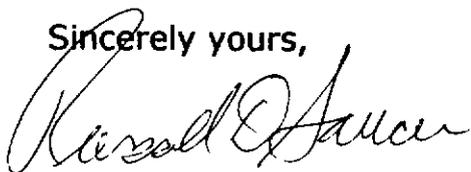
GPCIs
Centers for Medicare & Medicaid Services
Dept of Health and Human Services
Attn: CMS-1052-P
PO Box 8017
Baltimore MD 21244-8017

Sonoma County, California has suffered under the strain of inadequate medical compensation for more than a decade. Several medical groups have gone bankrupt, Health Plan of the Redwoods has shut down, employers have faced significant increases in health insurance premiums, and many doctors have left the county to practice where reimbursement is more favorable.

I, personally, have lost three doctors, (a cardiologist and two family practitioners) who left the state because they were being inadequately compensated. Some physicians are beginning to refuse new Medicare patients because of the same low reimbursement conditions.

By this letter, I am urgently requesting your support of the proposal of a new rule that will increase the reimbursement rate for Sonoma County.

Sincerely yours,



Russell D. Saucer
Tel: 707.838.2899

5237 Whispering Ck Dr,
 Santa Rosa, Ca. 95403
 Sept 5, 2005

SEP 14 2005

Medicare + Medicaid Services
 Dept of Health + Humane Serv.
 P.O. Box 8017
 Baltimore, Md 21244-8017
 Gentlemen & Ladies!

It has come to my attention that there is an inconsistency in the payments to doctors in Sonoma County. They should be paid the same as doctors in San Francisco, Marin County, and Napa County. You don't seem to ~~relate~~ ^{realize} the cost of living in Sonoma County is, according to statistics the third highest in the country. To even rent a chicken coop to live in costs \$800. One room in someone's house is \$650.00. Food prices are out of sight. The doctors, mostly the specialist are leaving because, to buy a 3 bedroom house, new, starts at \$750,000. This is not a town out in the sticks but an expensive place to live more so than Marin county. We have more people and good doctors are hard to come by.

My son wanted and needed a heart specialist to have a stent put in his left ventricle. He couldn't get a doctor, they weren't taking anymore patients. He tried for a month to get an appointment and finally a friend of a cardiologist in the city of Sonoma got a doctor from Sonoma to see him. Are you getting the picture now?

Sincerely,

Claire Light

age 83

P.S. I needed physical therapy and was turned down because they don't take medicare patients!!!

SEP 14 2005

**JOHN AND DEBRA CREVELLI
670 ALTA VISTA DRIVE
HEALDSBURG, CA 95448-4651
PH. (707) 433-4534**

September 5, 2005

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS - 1052 -P
PO Box 8017
Baltimore, MD 21244-8017

Re: GPCIs - Increase Medical Reimbursements In Sonoma County, California

Three years ago my wife and I underwent the trauma of having our HMO, Health Plan of the Redwoods, go bankrupt. in Sonoma County. This was the direct result of inadequate medical compensation to doctors, an inordinately low Medicare reimbursement rate. . We are still suffering the fallout effect of this today. A number of doctors have left the county. Some do not accept Medicare patients any longer.

We are treated as a rural county by your reimbursement pattern. We have outgrown that earlier rate by many years. Being in the "Rest of California" locality, (Locality 99), Sonoma County is severely penalized because, in reality, medical costs are substantially higher than "the rest of California". This is a high cost county in every way. Housing costs and basic cost of living reflect urban rates and not "rest of California" rates. Our economic realities are part of the urban San Francisco Bay Area. Indeed, we are an urban county trying to hold on to some agricultural land through the existence of vineyards. The rest of the county is urban in every sense of the word. Come visit our 101 Freeway some day and compare commute delays to those in the entire Bay Area. We are no different. And so it is in comparison of health care costs.

Realistically, it is time to make an adjustment, to redefine Sonoma County as a new locality. Doctors are consistently losing money. Doctors are moving away and it is difficult to attract new ones. Health Care is being jeopardized for the entire community because medicare reimbursement rates are so low .

Up to this time, we have had a talented and dedicated group of doctors in Sonoma County. We are proud of this fact and do not want to see this dedication diminished in anyway because of low Medicare reimbursement. Your office can do something about our apprehensions. You can go forward to maintain quality medicine in Sonoma County by creating a new locality for the County. It is time. In fact, it is past time. This should have been done years ago and we would have avoided the problems that have already hurt the HMO's, doctors and patients. Please do the right thing.

Sincerely yours,

John and Debra Crevelli



Sept. 3, 2005

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Centers for Medicare & Medicaid Services
Dept. of Health & Human Services
Attention: CMS-1502-P
P.O. Box 8017
Baltimore, MD 21244-8017

Re: GPCI

To whom It May Concern:

I am 83 years of age and receive excellent care from a dedicated, capable physician. I understand that the proposed rule will remove my county from the Rest of California physician payment locality designation.

I also understand that the physicians in my community will now receive payments from Medicare on par with other counties in the San Francisco Bay area.

We, my wife and I, wholeheartedly support the proposed changes that you have made, and greatly appreciate your attention and concern in this important issue.

Sincerely,

Grant A. Erickson



Grant Erickson
2435 Felt St. Spc. 95
Santa Cruz, CA 95062

6 September 2005

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1502-P
PO Box 8017
Baltimore, MD 21244-8017

Re: GPCIs

I understand that Medicare is proposing to create a new payment locality for Sonoma County, California. I would like to address some specific concerns from the perspective of a Sonoma County physician.

- Santa Rosa now ranks with retirement destinations such as Clearwater, St. Petersburg, and Miami, Florida.
- Among cities with a population of 100,000 or more, Santa Rosa is sixth in the United States for the highest percentage of people 85 and older.
- According to State of California Department of Finance, seniors 60 and older represent 16.6% of the total population in Sonoma County, with a projected rate of change of 196% by 2020.

Amid the astounding growth in our elder population, Sonoma County is facing strains on the health care delivery network that are unacceptable to Medicare recipients:

- The number of practicing physicians in Sonoma County has not kept pace with local population growth. From 1995 to 2002, the population increased 13%, but the number of practicing physicians increased by only 4%.
- As of July 2005, 60% of Sonoma County primary care physicians were NOT accepting new Medicare patients.
- Many physicians are leaving our county to practice where reimbursement is more favorable. As a result, many specialties are under-supplied. For example, we have only two gerontologists in the county for more than 76,000 seniors.

The new locality would increase the Medicare reimbursement rate to more closely match actual practice expenses, helping Sonoma County physicians improve the quantity and quality of care they deliver to Medicare beneficiaries and other patients. The locality change would also aid efforts to recruit and retain physicians in the county, which has a large Medicare population. I fully support your proposal to change Sonoma County's payment locality, and I appreciate the opportunity to comment on this important issue.

Sincerely,



Donald Minor, M.D.
4960 Rebecca Drive
Penngrove, CA 94951

370

Robert Nichols
7018 Oakmont Drive
Santa Rosa CA 95409-6302
Tel: 707 539 7437
e-mail - bobanick@sonic.net

SEP 4 2005

September 5th, 2005

GPCIs
Centers for Medicare & Medicaid Services
Department of Health and Human services
Attention: CMS-1052-P
P.O. Box 8017
Baltimore MD 21244-8017

We, absolutely, agree entirely with all this page says.

We have been told by a doctor friend, that until we in the city of Santa Rosa and Sonoma County as a whole are officially listed as "Urban" instead of "Rural," Medicare reimbursements will not properly recompense doctors for the services they provide.

Little wonder the doctors no longer want to accept medicare patients !

When you think that :

- (a) The population of Sonoma county from 1995-2000 has increased by 13 percent while the number of practicing physicians increased by only 4 percent !
- (b) In July 2005, six out of ten Sonoma County primary care physicians were NOT accepting new Medicare patients !
- (c) Many physicians are leaving our county to practice where reimbursement is more favorable !

Please do all within your power to correct this impossible situation.

Sincerely,


Robert & Barbara Nichols.



Meridian Gynecological Center

341

4 2005

August 26, 2005

Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention CMS-1502-P
P.O. Box 8017
Baltimore, MD 21244-8017

Dear Indiana Congressional Delegation:

I am a gynecologist who has been in practice for 13 years. I am very disheartened by the purposed 4.3% cut in Medicare reimbursement for physicians. Last year my malpractice went up 25% and my overhead went up 5%. With this 4.3% purposed cut physicians will soon be forced to leave medicine and find other avenues. Unfortunately the only people to suffer in this case will be America's aging population. Please do not let this happen for any of us involved. Thank you for your support.

Sincerely,

G. Alan Von Stein, M.D., F.A.C.O.G.

GAV/dlw

CC: Richard G.Lugar
Evan Bayh

Dear ~~Bob~~ McClellan:

9/1/05

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SEP 14 2005

Medicare's payment policy for anesthesiologists is discriminatory. Under current Medicare regulations, teaching surgeons and internists are permitted to work with residents on overlapping cases (2 for the surgeon) (4 for the internist) and receive full payment for each case so long as the teaching physician was present for critical or key portions.

Teaching anesthesiologists are permitted to work with residents on overlapping cases so long as they are present for the critical or key portions of the procedure. However, unlike teaching surgeons and internists, teaching anesthesiologists reimbursement from Medicare is reduced by 50% for each case. This penalty is not fair, it is not reasonable, and it is discriminatory. Medicare payment rules must be consistent across medical specialties.

Please end the anesthesiology teaching payment penalty.

Sincerely,

Verna L. Baughman MD
251 Marengo Ave
Forest Park IL 60130

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention CMS-1502-P
P.O. Box 8017
Baltimore, MD 21244-8017

SEP 4

Re GPCI

We are very happy with the medical care that we receive in Santa Cruz and would like to see our doctors receive adequate compensation for the work they do.

I hear that the doctors will now receive compensation from Medicare on a par with other counties in the San Francisco Bay Area.

We hope that this will come about and want to thank you for this change.

Your truly,

R. Zimmerman

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1502-P
PO Box 8017
Baltimore, MD 21244-8017

SEP 4 2005

September 4, 2005

Dear Sir,

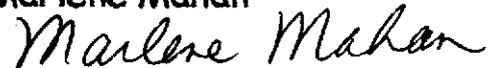
I am writing to ask you to change Sonoma County's payment locality to reflect the real costs of doing business here. To pay less here than Napa County is very outdated. The gynecologist who treated me very well, left Sonoma County several years ago due to her inability to make an income here. At a great loss to many, she moved her practice to Alaska. I want you to help keep the dedicated doctors we have left here by bringing equity to their payments. The cost of living in Sonoma County has risen dramatically in the past decade. This can only be considered an urban county under any analysis.

We have a large Medicare population that needs this parity to happen. I have a mentally ill son, Josh, for whom we have had great difficulty finding services from doctors who would take Medicare. At this point, he cannot afford to live here any more due to skyrocketing housing costs. I am on the Board of Directors of the National Alliance on Mental Illness, Sonoma County. We are constantly struggling with finding affordable housing and Board and Care Homes that can survive this urban economy.

Please support increasing the Medicare Reimbursements to Physicians in Sonoma County .

Sincerely,

Marlene Mahan



1903 Eversley Pl

Santa Rosa, CA 95403

cc: 2 copies enclosed

SEP 14 2005

September 6, 2005

GPCIs
Centers for Medicare & Medicaid Services
Dept. of Health & Human Services
Attn. CMS1052-P
P.O. Box 8017
Baltimore, MD 21244-8017

To Whom it May Concern:

I am writing to express my support for the new rule that would increase the reimbursement rate for Sonoma County, California by 8%. This proposal will bring Sonoma County back in line with current Medicare reimbursement standards, which will help stabilize our medical community.

Sincerely,



Rita McGowan
2994 Yulupa Avenue
Santa Rosa, CA 95405

cc: Copies (2)

5048 Alana Dr.
Santa Rosa, CA 95409
September 6, 2005 346

GPCIS
Center for Medicare & Medicaid Services
Department of Health and Human Services

Dear Sirs,

I am writing to express my concern about the inadequate Medicare reimbursement to doctors and care providers in Sonoma County. It is imperative that this situation be corrected NOW!

Costs of the median priced home is over \$600,000 in Sonoma County and Medical costs are over 8% higher than similar counties. I am troubled that when my physician retires I will not be able to find one who will care for a Medicare and Tricare patient. I am a nearly 78 year old widow of a military retiree (2 tours in Vietnam and 24 yrs. service) and wonder what I would do if no care is available

Please correct this situation and place us on an equal par with the rest of the expensive San Francisco Bay area!! Thank you for your attention to this matter.

Sincerely,
Olga Lee Mayberry

347

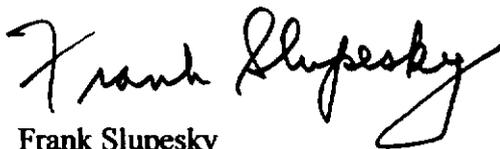
SEP 14 2005

September 9, 2005

GPCIs
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1052-P
B O Box 8017
Baltimore MD 21244-8017

Sonoma County, California has changed from a rural county to an urban county and I ask that you change the designation of Sonoma County, California to show this heavy population density so that the physicians in Sonoma County can afford to treat we seniors.

60% of the physicians in Sonoma County no longer take new medicare patients.



Frank Slupesky
550 Teresa Ct.
Sebastopol CA 95472

Tel 707-823-0909

Sept. 3, 2005

348

To Whom It May Concern,

SEP 4 2005

I was shocked to find out that the physicians in my area who administer to Medicare patients do not receive the same payments as those in other counties in the San Francisco Bay Area.

I wanted you to know that I certainly support the proposed rule to remove my county from the rest of California physicians payment locality designation, and to have the physicians in my community receive payment on par with other counties in San Francisco Bay Area.

Sincerely,

Elaine Wilson

349
Sept. 3, 2005

Dear CMS,

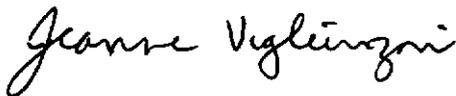
Please Help! Santa Cruz County in California is being unfairly classified as a "rural" county. Because of this classification, physicians here are being seriously underpaid for their services. The median price of a home in our area is \$700,000. We lose young doctors to nearby counties, like Santa Clara, because those counties are designated as "urban" and doctors are paid more there, even though the cost of living is the same as it is here in Santa Cruz. Many established doctors refuse to take anymore new Medicare patients.

Santa Cruz County is a beautiful place to live but we have a hard time recruiting new doctors to work here because the Medicare reimbursement is unfairly low. Other insurance companies follow Medicare payment guidelines. We have a shortage of important specialists such as neurosurgeons and neurologists. Why practice in Santa Cruz County when you can make 25% more in Santa Clara County ?

This unjust inequity is jeopardizing the quality of our health care system in Santa Cruz County. **Please correct this injustice. Change the classification for Santa Cruz County from "rural" to "urban" so that our doctors may be fairly reimbursed.**

Thank you.

Sincerely,



Jeanne Viglienzoni
420 Laurel Glen Rd
Soquel CA 95073

350

September 5, 2005

SEP 14 2005

G.P.C.Is.
Centers for Medicare &
Medicaid Services
Dept. of Health & Human Services
Attn: CMS-1052-P
P. O. Box 8017
Baltimore MD 21244-8017

Dear Folks,

We write to urge you to correct the badly out-of-balance Medicare reimbursements to our health care community here in Sonoma County in California. We are a county whose Medicare-age population is growing at a very high rate. It is estimated that people of that age already here comprise 17 percent of our county and that number will nearly triple by 2020.

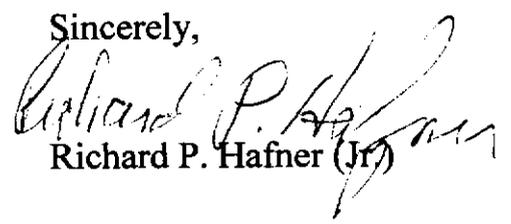
The other imbalance is the fact that the costs of medical care for those of us 65 and over (my wife and I are in our 70s) are just as high in Sonoma County as they in the San Francisco Bay Area, but reimbursement here is much less.

The combination of these imbalances is making it extremely difficult for us to retain the doctors we need and to maintain our beloved local hospital in Healdsburg, the hospital nearest to our farm.

We strongly urge you to make reimbursement of our doctors and hospitals fair so that our Medicare does indeed bring us the medical care that we must have to survive.

4290 Pine Flat Road
Healdsburg CA 95448

Sincerely,


Richard P. Hafner (Jr)

351

SEP 14 2005

September 7, 2005

Center for Medicare & Medicaid Services
Department of Health & Human Services

GPCIs

Attn: CMS-1502, P.O. Box 8017
Baltimore, MD 21244-8017

My husband and I have been residents of Santa Cruz County all but the first 10 years of our lives. I was born in Lemoore, California in 1926, and my husband was born in Crows Landing, California in 1915.

Santa Cruz County is growing by leaps and bounds, both in the city of Santa Cruz and in the city of Watsonville, as well as in the whole of the county. We have already had doctors who have moved to areas where they are reimbursed at a higher rate than in this county. Our doctors and other medical practitioners should have *at least* the same percent of reimbursement as our neighboring counties and other Bay Area jurisdictions.

The cost of living in Santa Cruz County is as high or higher than neighboring counties, yet treatment is reimbursed at a rate of 10 percent less. The federal government should make reimbursement judgments based on current cost-of-living information and not some 40-year-old designation that has nothing to do with 2005.

The immediate issue is about health care and not about a doctors-only salary. The cost of living in Santa Cruz County makes it difficult to attract good young doctors. They can make a lot more money elsewhere. Santa Cruz County is a great place to live and with just a little encouragement – and a little more money – good doctors can stay. This is particularly true for those who treat Medicare and Medi-cal patients. My husband and I are among the Medicare patients and we are asking you to give this matter your immediate attention.

Thank you,

Ella May Knapp

Ella May Knapp
Frank W. Souza

Frank W. Souza

610 Washington Street, Watsonville, CA 95076-4047

352

September 5, 2005

**Centers for Medicare & Medical Services
Department of Health and Human Services
Attention: CMS-1052-P
PO Box 8017
Baltimore, MD 21244-8017**

SEP 4 2005

Subject: GPCIs

We feel it is only fair and extremely important that Medicare payments to our doctors be increased to the same as doctors in Marin & Napa counties. The cost of living is very high in Sonoma County, rents, salaries, food, clothing, gas etc.

To continue to receive the care we need, our doctors must receive proper compensation, so that they can continue to practice in our County. At our age it would be very hard to travel to Marin or Napa for our care.

Regards,



**David H Brazil-Medicare #448-18-6440
Barbara B Brazil-Medicare #448-18-6440B
21183 Via Colombard
Sonoma, Ca. 95476**

This document contains information that is exempt from disclosure under the Freedom of Information Act, 5 U.S.C. 552, because it is a confidential source or method of obtaining information, or it is information that would disclose the identity of a confidential source, or it is information that would disclose the identity of a confidential source, or it is information that would disclose the identity of a confidential source.

September 6, 2005

SEP 14 2005

Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-1502-P
PO Box 8017
Baltimore, MD 21244-8017

Re: GPCIs

Being citizens of Sonoma County we see the need to create a new payment locality for Sonoma County. We hear doctors talk about the low reimbursement rates and read in the newspaper about doctors leaving the area because of the lower reimbursement rates. Why should they stay here when they can get better rates elsewhere? This puts the citizens of our county at a great disadvantage.

We fully support your proposal to change Sonoma County's payment locality. Thank you for allowing us to have input on this important matter.

Sincerely,



Robert & Alice Gloeckner
4800 Hessel Rd.
Sebastopol, CA 95472

cc: Two copies attached

Annabelle Garetz
P. O. Box 107
101 Anchorage Close
The Sea Ranch, CA 95497

9-6-05

Centers for Medicare & Medicaid Services
Dept. of HHS

Attn: CMS-1502-P

Dear Sir or Madam,

Please enact the new rule that would increase the reimbursement rate for Sonoma County Doctors who provide services to Medicare and Medicaid patients by the proposed 8%.

I am on Medicare and have had wonderful care from the specialists in Santa Rosa which is 70 miles from my home (and I am 84). It would be impossible for me to travel further - but equally impossible for them to keep their offices open at current reimbursement rates with the extremely high cost of living in Sonoma County.

Sincerely,

Annabelle Garetz

September 6, 2005

58 Oriole Way
Santa Rosa, California 95409

Centers for Medicare and Medicaid Services
Department of Health and Human Services
CMS-1052-P

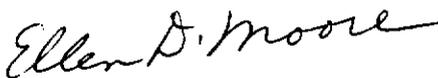
Dear Sir or Madam:

This letter is to let you know how critical it is for Sonoma County, California to have an increased reimbursement for all Medicare patients. We must be able to pay our doctors, keep our doctors, and have all the medical care that we need. Please readjust our medical compensation to its fair level and make it possible for health providers to compete within northern California. Thank you.

Sincerely,



Robert J. Moore, age 75



Ellen D. Moore, age 69

9-6-05

356

SEP - 4 2005

To Medicare administrators;

Due to our County (SONOMA) suffering under the strain of inadequate medical compensation for more than 10 years and tremendous growth of elder population we definitely support the new rule to increase the reimbursement rate for Sonoma County, Calif. by 8%.

Thank you very much.

Judy Ann Fletcher
5839 YERBA BUENA ROAD
SANTA ROSA, CA 95409

Robert Ash Fletcher
5839 YERBA BUENA RD.
SANTA ROSA, CA 95409

GPCI

Sept 3, 2005

SEP 4 2005

I am a resident of Santa Cruz County.

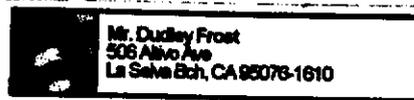
Santa Cruz is no longer a rural area.

Our doctors deserve the same reimbursement as doctors in other developed regions.

Gail Peast
506 ALTIVO AVE
LA SELVA, CA 95076

GPCI

358



7/3/05

I LIVE IN SANTA CRUZ CO.
CALIFORNIA. (ZIP 95076)
WE ARE NOT A RURAL COUNTY.

SANTA CRUZ IS 30 MINUTES OR
LESS FROM CENTRAL SANTA CLARA CO
(SILICON VALLEY).

LIVING COSTS, HOUSING COSTS ARE THE
SAME OR MORE THAN NEARBY FULLY
DEVELOPED BAY AREA COUNTIES ..
DUE MEANWHILE HOUSING PRICES @ * 750,000

* DOCTORS MUST HAVE THE SAME
REIMBURSEMENT AMOUNTS HERE IN
SANTA CRUZ OR WE WILL CONTINUE
TO LOSE DOCTORS TO OTHER AREAS.

Reimbursement (SENIOR ON MEDICARE)

JIM AND CAROL MCCONNELL
5595 VINE HILL RD.
SEBASTOPOL, CA 95472-2041

September 6, 2005

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1502-P
PO Box 8017
Baltimore, MD 21244-8017

Re: GPCIs

The undersigned are Medicare beneficiaries who receive medical care from physicians in Sonoma County, California. We fully support your proposal to reclassify the Sonoma County payment locality by 8% as quickly as possible because of the following:

1. The cost of delivering medical services locally has risen substantially.
2. Sonoma County has an abnormally large number of senior citizens receiving Medicare benefits.
3. A high percentage of doctors have refused to accept new Medicare patients due to economic necessity.
4. The number of doctors leaving for greener pastures is growing daily.
5. It is difficult to attract doctors to practice here because the unfairly low reimbursement schedule.

We are suffering the consequences and need your help on an immediate basis.

Thank you for the opportunity to comment.

Sincerely,


Carol L. McConnell


James F. McConnell

5595 Vine Hill Rd.
Sebastopol, CA 95472-2041

cc: two copies attached.

360



Mary Woodward Priest

242 Dover Court, North · Santa Rosa, California 95403 · Telephone (707) 546-8944

September 9, 2005

GPCIS
Centers for Medicare & Medicaid Services
Department of Health & Human Services
P. O. Box 8017
Baltimore, MD 21244-8017

Attention: CMS-1052-P

In Re: Payment Schedules for Sonoma County, California

Through the years I have written many letters to Members of Congress regarding the inadequate pay rates for Medicare payments in this area. To even describe Sonoma County as "rural" is a misnomer. The cost of living here has increased at a much greater rate than in many areas of the country and it is past time for an adjustment upward in the rates being paid to our doctors and hospitals.

We are a county with a large population of retired residents who fall in the Medicare category. Our older doctors are retiring and our younger doctors are moving away. Many are being forced into not accepting new Medicare patients. We are increasingly challenged to secure appointments.

Please fix this inequity.

Sincerely,

Mary W. Priest
Mary W. Priest

Enc. 2 Copies

A note from... 361

Mr. & Mrs. Herbert Passarini

SEP 14 1985

8/5/05

To Whom It May Concern,

We live in Sonoma County.
We have excellent doctors
in the county that we feel
are entitled to the same
reimbursement rate as the
doctors in Marin & Napa.

We want to keep our doctors.
They have saved my husband's
life as well as my own.

Please consider an increase
for our very special doctors.

Sincerely,
Herbert & Dorothy Passarini.



362

3039 Las Mesitas Court
Santa Rosa CA 95405
September 7, 2005

SLI 1/1/000

To Whom It May Concern:

We have been residents of Sonoma County for 22 years. During that time, the population of Santa Rosa has almost doubled, and the population of elderly retirees has increased significantly. At the same time, rising home prices have made what was once the poor sister of the Bay Area into an extremely expensive place to live.

We have watched many physicians leave the area and as Medicare patients, been directly impacted by closed practices and long waits to see specialists.

An increase in Medicare reimbursement to this area's doctors is, we feel, long overdue and we vigorously support this proposed adjustment. Unless something is done we fear for our future health care treatment.

Yours sincerely,

Ruth and Glyn Pritchard

Ruth & Glyn Pritchard

September 8, 2005

GPCIs
Centers for Medicare and Medicaid Services
Dept. of Health and Human Services
Attention: CMS-1052-P
P. O. Box 8017
Baltimore, MD 21233-8017

Dear Sirs:

We are urging the Department to raise the Medicare reimbursement rate to doctors in Sonoma County by 8% to equal other Bay Area counties in California.

As Medicare-enrolled members it is imperative that our doctors here continue to accept Medicare patients. This County has a high percentage of retirees, we are entitled to adequate medical care.

Passage of higher medical reimbursement would permit existing doctors to remain in the area as well as attract additional ones. As well as permit the current doctors to once again accept Medicare patients.

Sincerely



George and Isabel Baker

4917 Kinsington Ct.
Santa Rosa, CA 95405

364

Sara Long
1163 Hopper Ave. #178
Santa Rosa, CA 95403

To Whom it May Concern -

Medicare must increase the reimbursement rate for Sonoma County by 890. This proposal will bring Sonoma County back in line with current Medicare reimbursement standards, which will help stabilize our medical community. I support this new rule that Medicare has proposed.

Sincerely,
Sara A. Long

365

September 10, 2005

To Whom it may concern: SEP 14 2005

We propose that Medicare
increase the reimbursement
rate for Sonoma County by 8%

Thank you,

George and Rose Calvo

CENTERS FOR MEDICARE & MEDICAL SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

ATTENTION, CMS-1052-P

PO Box 8017

Baltimore, MD. 21244-8017

SIRS:

Are you aware that in Sonoma County California that 6 out of 10 Sonoma County PRIMARY CARE PHYSICIANS are not accepting new Medicare patients. Many of our PCP are leaving our county to practice where reimbursement is more favorable.

We here in Santa Rosa (Sonoma County) with a population of OVER 100,000, are 6th in the UNITED STATES for the highest percentage of PEOPLE 85 and over. (I am 72) We need HELP we need to KEEP our wonderful physicians, not chase them away with POVERTY level reimbursements.

My doctor is planning to retire soon. Will YOU take care of me? Sonoma County has the LOWEST REIMBURSEMENT rate in CALIFORNIA

PLEASE HELP US.

Margy McKeever RABSN
2850 Creekside Rd.
Santa Rosa, Ca 9540
707-544-4089



From The Desk Of
Harold D. Mattos

367

Sept. 10, 2005

U.S. Dept. H + H Services
Center for Medicare
Baltimore, MD

Gentleman:

My husband and I know first-hand many doctors who left Petaluma Valley Hospital, Petaluma, CA these past ten years. These doctors treated us with great care, but were not adequately reimbursed. They went to other hospitals out of Sonoma County. We have known of this problem for years and have brought it to the attention of our Congresswomen.

It is past time that our doctors are reimbursed fully for their services. We are no longer a rural county. My husband is presently again in Petaluma Valley Hospital and is receiving excellent care. We do not want to lose more doctors. It is now time to correct this hardship, which is unfair to our dedicated doctors who save our lives.

Sincerely,

Honoraria Mattos

"Veterans Serving Veterans"

108 Oakwood Dr., Petaluma, CA 94954

368

1165 Montgomery Drive
Santa Rosa, CA 95405-4801

P.O. Box 522
Santa Rosa, CA 95402-0522

707.546.3210 Tel

September 8, 2005

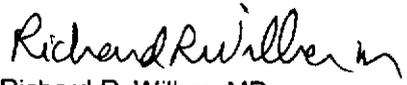
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1502-P
PO Box 8017
Baltimore, MD 21244-8017

RE: GPCIs

It has come to my attention that Medicare has a proposal to create a new payment locality for Sonoma County. Because Sonoma County is such an increasingly expensive place to live and work, the new Medicare reimbursement rate would be more closely matched to actual practice expenses than it is now. There is no question that the new locality would help Sonoma County physicians improve the quantity and quality of care they deliver to Medicare beneficiaries as well as to other patients. The locality change would certainly benefit efforts to recruit and retain physicians in the County, which has a large Medicare population.

For the above reasons, I fully support your proposal to change the payment locality for Sonoma County. Also, I appreciate the opportunity to comment on this important issue.

Sincerely yours,



Richard R. Wilber, MD
Medical Director Santa Rosa Memorial Hospital Clinical Laboratory

Department of Pathology, 2W10
1165 Montgomery Drive
Santa Rosa, CA 95405

CC: Two copies attached

369

O'Brien
Watters
& Davis LLP

Attorneys at Law

John R. O'Brien

JO'Brien@obrienlaw.com

September 9, 2005

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1502-P
P.O. Box 8017
Baltimore, MD 21244-8017

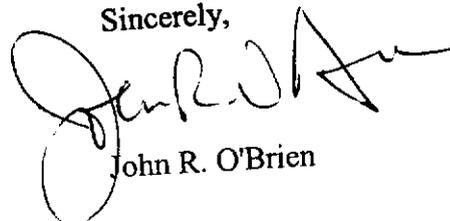
Re: GPCIs

I am an attorney, and our firm represents numerous Medicare beneficiaries who receive medical care from physicians in Sonoma County, California. I understand that Medicare is proposing to create a new payment locality for Sonoma County, which is an increasingly expensive place to live and work. In the new locality, the Medicare reimbursement rate would be more closely matched to actual practice expenses than it is now. I have seen many physicians leave Sonoma County to practice elsewhere due to the low Medicare reimbursement rate that now exists. Also, many physicians now refuse to see Medicare patients.

The new locality would help Sonoma County physicians improve the quantity and quality of care they deliver to Medicare beneficiaries. The locality change would also assist greatly in the recruitment and retention of physicians in the county, which has a very large Medicare population.

I fully support your proposal to change Sonoma County's payment locality, and I appreciate the opportunity to comment on this important issue.

Sincerely,



John R. O'Brien

JRO/nbc

2 copies attached

G:\office\JRO\Letters\Centers for Medicare JRO 9 9 05.doc

Sept 6, 2005

SEP 4 2005

To: Centers for Medicare & Medicaid
Dept. of Health & Human Services

Re: Sonoma County, CA
Medicare Reimbursements

Please change federal guidelines
to increase the reimbursement
rate for Sonoma County by 8%.

Sonoma County, CA has the lowest
Medicare reimbursement rate
in California - & our elder
population is exploding.

In July 2005, six out of ten
Sonoma County primary care physicians
were NOT ACCEPTING new Medicare
patients!

We need assistance.

Joan Wion

To: Centers for Medicare & Medicaid Services
Department of Health & Human Services
PO Box 8017
Baltimore, MD, 21244-8017
Attention: CMS-1052-P

Sept., 6, 2005

From: Joaquin R. Espinosa &
Audrey D. Espinosa
229 Red Mountain Dr.
Cloverdale, 95425 County of Sonoma, Calif.

Subject: GPCIs

To Whom it may concern:

As residents of Sonoma County, California my wife and I have been aware for some time of the disparity in reimbursement rates that our County receives as compared to other counties in California. In fact, despite the large growth rate of Seniors in the County, the Medicare reimbursement rate is the lowest of the 58 counties in the State.*

Just recently we have become aware that Medicare has realized the need to fix this disparity and has proposed a new rule to adjust the county's reimbursement upwards to eight (8%) percent. This would be in-line with the neighboring counties of Marin & Napa which are classified as "urban" counties.

There is an urgent need for Medicare to address this rate disparity in Sonoma County; here are some of the reasons why: **

- Seniors (60 & older) currently represent 16.6% of total population in Sonoma County with a projected rate of change of 196% from the year 2000 to 2020.
- Among cities with a population of 100,000 or more, Santa Rosa (Sonoma County) is sixth in the United States for the highest percentage of people 85 and older.
- Over a seven year period (1995-2002) the County population increased by 13% and the number of practicing physicians increased by only 4 %.
- Over the same period, 32 % of the physician population no longer practice medicine in Sonoma County.
- Many physicians are leaving the county to practice where reimbursement is more favorable.
- In July, 2005, 6 out of 10 Sonoma County primary care physicians were not accepting new Medicare patients.
- The young doctors that that the County needs are not coming here; only 14% of Sonoma County's doctors are under age 40 while 24% are over age 60.

We, the undersigned, respectively urge CMS and the Dept. of Health & Human Services to create a new "payment locality" for Sonoma County and increase the county's reimbursement rate by 8%.

Joaquin R. Espinosa (age 71)

Joaquin R. Espinosa
Audrey D. Espinosa

Audrey D. Espinosa (age 69)
Cloverdale, Sonoma County, California.

* Santa Rosa Press Democrat, August 30, 2005 pg. D5.

** Sonoma County Medical Association, Santa Rosa, Ca. 95403. (July, 2005).

TEB CJB

102 Katherine Lane
Santa Cruz, CA 95065
beaubaux@cheerful.com

312

September 9, 2005

September 9, 2005

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1052-P
P. O. Box 8017
Baltimore, MD 21244-8017

Re: GPCI

Greetings:

I understand that you are considering the removal of Santa Cruz Country from the Rest of California physician payment locality designation. If approved, it is my perception that Santa Cruz County physicians will receive Medicare payments comparable to other counties in the San Francisco Bay Area. I strongly support this proposed change, since it will enable physicians to be more equitably compensated relative to the high cost of living in this area.

Thank you for your attention to this.

Sincerely,



Truett E. Bobo



Kevin K. Tremper, Ph.D., M.D.
Robert B. Sweet Professor and Chair
Department of Anesthesiology
1H247 University Hospital, Box 0048
1500 East Medical Center Drive
Ann Arbor, MI 48109-0048
(734) 936-4235
(734) 936-4006 fax
ktremper@umich.edu

373

August 24, 2005

SEP 14 2005

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P
P.O. Box 8017
Baltimore, MD 21244-8017

RE: CMS-1502-P Teaching Anesthesiologists

Dear Sir:

The purpose of this letter is to express my strong recommendation that you reverse the unfair payment practice for teaching anesthesiologists. Anesthesiologists are the only teaching physicians who have their reimbursement cut in half when teaching residents. All other specialties receive 100% reimbursement. This unfair practice has led to progressive financial difficulties in nearly every teaching program in the U.S. Over the last five years I have surveyed the financial status of teaching programs and the faculty vacancies in those anesthesia residency training programs. What we have found is that there has been a progressive need for the teaching institutions to provide more and more funds to their departments' of anesthesiology to enable them to remain solvent. In 2000 each department received approximately \$30,000/faculty and in 2004 that had risen to \$95,000/faculty in the average teaching anesthesia department. In spite of this there are still a significant number of faculty positions open in these departments (10% vacancy rate of anesthesia faculty). (1,2,3,4)

These surveys were initiated when I was the president of our chairs' organization (SAAC/AAPD). We have continued these surveys and noted the progressive deterioration of the financial status of these programs. In the financial analysis it was noted that the reimbursement rate, especially from Medicare, was extremely low. The average reimbursed unit value for anesthesia was in the range of \$10/unit where the average charge is \$75/unit. This charge to reimbursement ratio is substantially lower for anesthesiologists than any other medical specialty reimbursed by CMS.

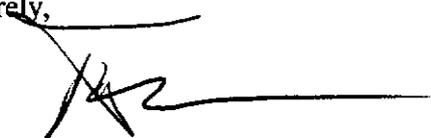
Anesthesiologists in private practice have the opportunity to supervise up to 4-on-1 CRNAs, thereby receiving a reasonable reimbursement, although still low in comparison to other specialties in medicine. Teaching anesthesiologists can only supervise a maximum of two residents simultaneously, thereby placing teaching anesthesiologists and their departments at significant financial disadvantage relative to the private practice community. This has resulted in a continuous drain of faculty talent from University programs into the community, making it more difficult to sustain the production of well qualified anesthesiologists for our country. Since the late 1990s a shortage of anesthesiologists has progressively grown to the point where we feel there is an

CMS-1502-P
Teaching Anesthesiologists

approximate shortage of 3,000 to 4,000 anesthesiologists, while we train only 1300/year. One of the issues in training an adequate number of anesthesiologists relates to the ability to attract and retain academic faculty in teaching programs.

In conclusion, I strongly recommend that CMS reconsider changing the reimbursement methodology for teaching anesthesiologists so that they may receive 100% payment while supervising a maximum of two residents providing patient care. This has been a long-standing inequity which is aggravating the current financial problems in teaching departments and the nationwide issue of an anesthesiologist shortage. Thank you very much for your consideration.

Sincerely,



Kevin K. Tremper, PhD, MD
Robert B. Sweet Professor and Chair
Department of Anesthesiology

KKT:jjm

Cc: Governor Jennifer Granholm
Senator Carl Levin
Senator Debbie Stabenow
MI Congress Representatives

Attached References (1,2,3,4)

**Surviving the Perfect Storm:
The Financial Environment of Academic Anesthesia
October 2000**

**Kevin K. Tremper, PhD, MD
University of Michigan
Committee Chair**

**Steven J. Barker, PhD, MD
University of Arizona**

**Simon Gelman, MD
Brigham & Women's Hospital**

**Calvin Johnson, MD
Charles R. Drew University of Medicine & Science**

**Joseph G. Reves, MD
Duke University**

**Albert J. Saubermann, MD
Albert Einstein College of Medicine**

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EXECUTIVE SUMMARY

In the fall of 1999 the SAAC/AAPD council charged a subcommittee to produce a white paper to assess the financial well being of our training programs. Because of progressive pressures on professional fee reimbursement, additional financial constraints placed on teaching hospitals and a projected anesthesiology manpower shortage, it was felt such a report was needed to provide information to its members, the council and our society in general. The report is divided into five sections: Manpower, Medicare Reimbursement, Published Data, SAAC/AAPD Financial Survey and Strategies for Improving Financial Well Being. The first three sections are meant to provide background information regarding these issues. The survey provides a snapshot of the current status of our training departments and the final section attempts to provide some methods for managing the problems.

Manpower In Anesthesiology: It is clear that the dramatic reduction in residents in the mid 1990's has now resulted in a severe manpower shortage. The number of applicants dramatically dropped as well as the percentage of AMG graduates entering our field. In 1995 there were 1,863 graduating residents, 1,547 of which were AMG's. The graduating class of 2000 was 991 graduates, only 392 were AMG's. This increasing percentage of IMG graduates is concerning because of the consequences of their visa status. It is unknown how many of these IMG residents are training on J1 visas which require them to return to their home country. If a large proportion of the IMG residents fall into this visa category, then the number of resident graduates available for the workforce will reach 811 by the year 2003 which is little more than half the number of graduates completing training each year in the early 90's. This shortage is confirmed by the results of the survey which estimates there are 490 open faculty positions in our teaching programs as of August 2000. We conclude from this manpower analysis that there is a substantial shortage of anesthesiologists which will continue for the foreseeable future.

Medicare Reimbursement: Anesthesiologists are reimbursed differently by Medicare and other payors from all other physicians. The RBRVS/RVU methodology that HCFA uses to reimburse other specialties has not been successfully applied to anesthesiology. Our time based methodology makes our specialty unique with respect to reimbursement and under

valued by Medicare. For this reason it is important that group practice reimbursement methodologies do not use multiples of Medicare for anesthesiology services. In addition to professional reimbursement issues for anesthesiologists, the Balanced Budget Act of 1997 has placed progressive pressures on teaching hospitals. As hospitals face financial pressures, there is a greater risk that they may withdraw necessary support from anesthesiology departments and their training programs. In spite of these reduce payments, hospitals do receive significant payments to not only offset the hospital costs associated with resident training but also the faculty costs of training those practitioners. It is important that department chairs understand this hospital reimbursement methodology to assure that their departments receive the appropriate support from those federal funds.

Published Data: AAMC, MGMA & SAAC: Several national organizations present publish statistical data on faculty compensation, faculty productivity and group practice expenses. Academic anesthesiologists make lower salaries and their practice expenses are higher than private practice anesthesiologists. Overall the practice expenses for private practice are approximately 10% of revenue which is dramatically less than those of other subspecialties which range from 28% to 56%. Overhead in academic anesthesia departments is in the range of 20%. This places training departments at a financial disadvantage when trying to recruit faculty at competitive salaries. Data also suggest that anesthesiologists in academic departments spend more time in clinical activities compared to their academic colleagues in other disciplines.

SAAC/AAPD Financial Survey Results: In the spring of 2000, a comprehensive financial survey was sent to all SAAC/AAPD members. Data are from the academic year ending June 1999. An overall response rate in the analysis was 56% which compares well with the MGMA response rates of 25 to 30%. From this survey our faculty average 69% of their time in clinical care, 16% in teaching, 8% in research and 7% in administration. Half of the departments pay for none of their residents and in the other half they pay for some residents. With respect to non-ACGME fellows, departments pay for all positions in 54% of the institutions. The departments fund 100% of the CRNA's in 44% of institutions, while the hospital funds 100% of CRNA's in 34%. In the detailed financial analysis, the departments were divided into three categories. The Academic Medical Center Model (AMC) where the department is in a medical center, where they pay taxes to their medical

school and group practice and receive support from their hospital and medical school. In this AMC model departments are responsible for their revenue and expenses. A second model has been described as the "Budgeted" Model where departments are within large clinics, county organizations or group practices in which the funds flow is better described as a budgeting process. In these departments, revenue and expense data are not readily available. A third group has been described as the Independent Practice Model (Independent Model) where the department pays little or not taxes to a medical school or a group practice but receives little support and therefore more closely resembles an independent practice. For much of the financial analysis the budgeted model does not apply and is therefore not included in the preliminary data analysis.

Hospital Support: Overall our departments receive support for a variety of services which include OR management, obstetrical anaesthesia, critical care management, preoperative clinics and general administrative support. The support averages \$1,235,474 per year or \$34,318 per faculty member. The department support is significantly less in the independent model, \$442,884 per year or \$17,034 per FTE. Overhead expenses as one might expect are greater for the AMC model, averaging 20%, while the Independent Model overhead expenses are 10% of revenue. The average professional fee charge nationwide is \$62.60 with an overall collection rate of 42.5%. Physician compensation accounts for 68% of the expenses in the AMC model while it accounts for 80% in the Independent Model. Overall 53% of our institutions had a positive overall margin for the 1999 fiscal year, while 44% had a negative margin. The positive margin was \$50,481 per faculty and the negative margin averaged \$23,814 per faculty.

Current Faculty & CRNA Openings: A survey conducted in the second week of August found that there were 3.8 faculty openings per department (326 open positions in the 94 departments who responded to the survey). This would project to approximately 490 openings across all academic departments. In the 66% of departments who stated they needed additional CRNA's, they had an average of four open positions resulting in a projection of 369 open CRNA positions in these departments.

Strategies for Improving Financial Well Being: Given the fact that there is clearly a shortage of faculty anesthesiologists, it is imperative that departments optimize their

finances to be able to recruit faculty and maintain their academic programs to retain those faculty. Strategies to assist in this process include the following: Ensure that contracts with payors are not written as multiples of Medicare reimbursement for that methodology under values anesthesia services. Ensure that your department receives its adequate share of DME funding given its responsibilities for resident training. Ensure that the department receives appropriate support from the hospital to support clinical and administrative services provided by the department. Determine an appropriate size of the house staff with respect to academic and educational needs and balance that against clinical service. Additional service requirements may require support from the hospital. Ensure that your department receives adequate payment for capitated contracts by comparing anesthesia work units to RVU's of other specialties in a way that accurately describes the work and the reimbursement between departments proportionate to private practice incomes. Chairs should know the minimum unit value they can accept in any contract that ensures a positive margin on that incremental activity . They should also know the renewal dates of all third party payor contracts. Finally the department chairs need to provide non-monetary benefits to faculty to recruit and retain them in the academic environment, such as support for their academic programs, flexible working hours and supportive working environment.

The following report reviews each of these topics in more detail and hopefully will be of value to chairs as they plan for future discussions and negotiations with their deans, hospitals and third party payors. The report also includes a detailed appendix of all the data from the SAAC/AAPD financial survey.

INTRODUCTION

The past decade has seen unprecedented changes in the management of health care, which have placed academic medical centers at significant financial risk. In the early portion of the decade managed care plans grew significantly, reducing fee for service income and progressing toward a capitated environment in some markets.¹ The financial risk was shifting from insurers to the providers. Hospital patient length of stay dramatically reduced resulting in decreased occupancy with predictions that hospitalizations and surgical procedures may progressively reduce along with reimbursement. Health care planners envisioned a future with primary care gatekeepers which would decrease the need for specialists. In 1997 HCFA capped the number of residents for GME reimbursement and even proposed financial incentives to institutions who would voluntarily reduce their number of house officers. Academic medical centers strived to produce a greater number of primary care trainees to meet the anticipated demand for these new gatekeepers of capitated care. Many academic medical centers expanded their primary care base by buying practices thereby ensuring their referrals to maintain academic and financial viability.

At the height of this push for primary care, the field of anesthesiology appeared to be targeted as one with an over supply that would be especially impacted by decreased surgical procedures resulting from full capitated care.² 1995 saw a shocking reduction in medical school applicants to anesthesiology programs. The graduating CA-3 class in 1994 was 1,843 while the entering CA-1 class for 1996 was only 745.³ Although this class was ultimately supplemented to 885, this is still approximately 1,000 less than the graduating classes during the peak years of the early 1990's.³ Nearly all training programs suffered a substantial drop in their number of residents and the field noted a dramatic increase in the percentage of international medical graduates (IMG) (10% in 1990 to 57% in 1999).³ Managing an academic program while providing the necessary clinical service was a challenge with the residencies cut in half. This staffing problem has placed a significant stress upon the faculty of these training programs as well as the financial resources of the departments and the institutions in which they are inexplicably bound. To make a difficult financial environment even worse, Congress passed the Balanced Budget Amendment in 1997 in which HCFA would progressively reduce GME reimbursement to teaching hospitals.^{4,5} The result has been a progressive decrease in training hospital's profitability

where many academic medical centers are either in the red, some to a dramatic degree, or are predicting progressive financial difficulties as the Balanced Budget Amendment is implemented.^{5,6} Ironically this has occurred during a decade in which the US economy has been remarkably strong, producing a positive federal budget.

Academic department's of anesthesiology enter the new millennium facing the confluence of three adverse financial pressures: decreased professional fee reimbursement, working within academic medical centers that are struggling to remain financially viable and trying to retain academic faculty in the best job market for anesthesiologists in twenty years. The reduction in resident class size in the late 1990's has obviously resulted in the decreased availability of trained anesthesiologists today. As the overall job market has improved, the academic "life" has progressively deteriorated. When the number of residents decrease, academic faculty are required to spend a greater and greater portion of their time providing service thereby limiting time for academic development. It may be difficult for some faculty to determine the difference between an academic position and a private position other than a lower salary.^{7,8} With hospitals trying to meet their budgets, there are greater pressures to shift costs to the academic departments by not providing the necessary support. The demands for more clinical productivity with less support have placed the academic department under unprecedented financial stress.⁶

In the fall of 1999, the SAAC/AAPD Council felt that it was important to analyze the current financial status of its training departments. Simon Gelman, MD, SAAC president, charged a task force to produce a white paper on the current financial environment threatening the health of our training programs. The following report is composed of five sections. The first section titled **Manpower in Anesthesiology** provides a brief history of manpower in our field with the predictions for the near future. Since academic faculty are the heart of the training program, it is essential that we recruit the next generation of teachers. The second section titled **Medicare Reimbursement: Past, Present and Future** reviews the development of the current Medicare reimbursement system and how it disadvantages our specialty. This section also reviews both Direct (DME) and Indirect (IME) Medical Education reimbursement to hospitals, how these funds are derived, their designated uses and how they will be affected by the Balanced Budget Amendment. It is clear that if academic medical centers are in financial difficulty, those difficulties will be shared by the

training programs within those institutions. The third section titled **Published Data: AAMC, MGMA and SAAC** reviews the data, which are published yearly by each of these organizations. This information covers a wide range of useful statistics with respect to physician salaries, both academic and private practice, costs of practice and productivity measures in all specialties. This information can be useful when determining the appropriate costs departments of anesthesiology should pay in managing their practices. It also is important for department chairs in anesthesiology to be aware of the data, which are reviewed by medical school deans and hospital administrators when they are determining necessary departmental support. Section four titled **SAAC/AAPD Financial Survey** will present the results of a survey distributed to SAAC/AAPD members in Spring 2000. These data will provide useful information comparing our departments, the resources made available to them by medical schools and hospitals as well as the clinical and financial obligations charged to our departments. The final section titled **Strategies for Improving Financial Well Being** provides a list of strategies that may be useful in negotiating the support required to maintain an academic department.

Finally it is hoped that the information provided in this report will not only be helpful to individual department chairs but also to the leadership of our specialty when they work with our medical societies and government agencies to address our current difficulties.

Section I - Manpower in Anesthesiology

According to a survey of SAAC/AAPD departments as of August 2000, there are approximately 490 open faculty positions or an average of 3.8 open positions per department (Section IV, page 35). The reasons for this faculty shortage appear to be a reduced number of graduating residents and a very healthy demand for anesthesiologists. The result is that many academic anesthesiology chairs, feeling under pressure from deans, senior hospital administrators, as well as from surgeons to provide anesthesia for growing clinical practices find themselves severely short of manpower. In addition thinned out ranks of faculty are putting pressure on anesthesiology chairs to replenish the manpower so that the work is more evenly distributed to allow some time to pursue academic activities. These faculty, now finding that they are mainly providing clinical care, wonder why they are remaining in an academic practice. Facing lower salaries than private practice and doing similar work, faculty members are being recruited away from academic departments.^{7,8}

This problem is both a financial issue and a manpower issue. In a fully free market system, the laws of supply and demand largely determine manpower cost and availability. If the available manpower is not sufficient to meet demands there will be increased competition for that manpower leading to its increased production. Our medical professional educational systems are not a fully free market system. A number of market-affecting factors have contributed to significant challenges for academic anesthesiology trying to provide enough qualified academic faculty to fulfill clinical care, educational and academic missions. To understand the origin of the current faculty shortage, it is necessary to examine overall manpower in anesthesiology.

HOW MANY ANESTHESIOLOGISTS ARE ENOUGH?

One of the first questions is how many people are actually needed to do the work. This question has two major variables namely how much work will there be and who will do it. Unfortunately, the question of what will be the right amount of manpower for the future is not easily determined. Efforts to answer this question were undertaken by ABT Associates Inc. in a 1994 report written for the ASA.⁹ The ABT report looked at four different models of care (physician intensive, two types of physician/CRNA teams, and CRNA intensive) to

try to answer the question of who will deliver the care. ABT also made certain key assumptions about the number of anesthetics likely to be given to try to answer the question of how much work there will be. From these assumptions an estimate of future manpower needs could be made based upon the care model chosen. Difficulties with such a projection have been the unpredictability of demand for anesthesia (since managed care's impact on the number and type of procedures requiring anesthesia is uncertain) and an uncertain but growing demand for specialized subspecialty expertise. Further, the assumptions about which practice model will prevail is not at all clear at this point although the demographics suggest the number of physician providers will continue to grow at a faster rate than CRNA providers. If the future needs could be predicted, then theoretically it should be possible to train the right number of new anesthesiologists, although efforts to manipulate the supply/demand equation has not worked well in other areas.

HISTORY

The growth of our specialty has followed the growth of academic anesthesiology departments. The advancement of our knowledge brought our specialty into the mainstream of academic medical schools and promoted the demand for consultant specialists in the community. As the demand for high quality anesthesia administered by specialist physicians grew there was an increase in the number of academic anesthesiology departments and the size of our training programs (Figs. 1 & 2). The work force, including CRNA's grew steadily from 1969 to 1994 when it appeared to level off (Fig. 1).

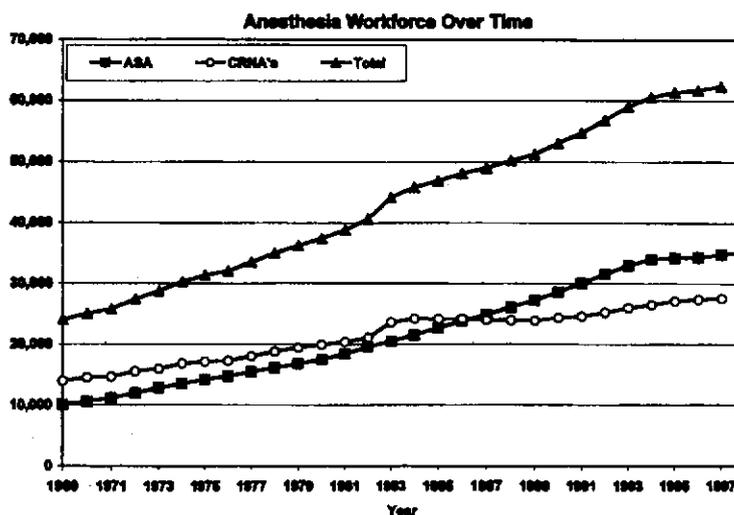
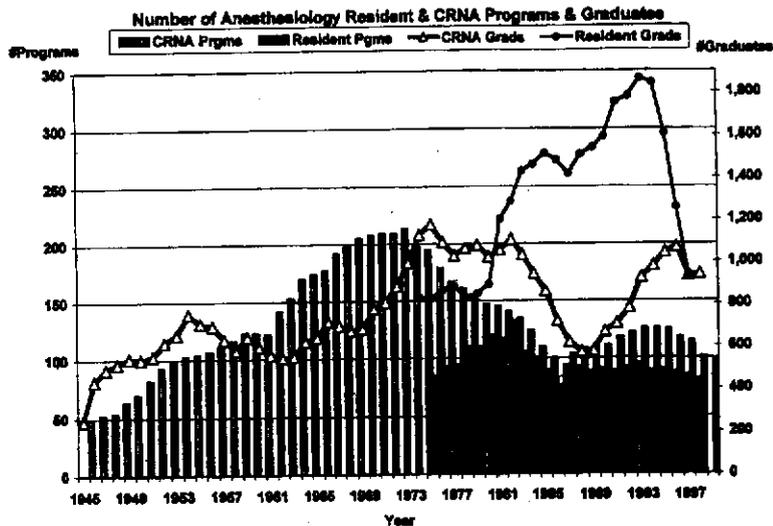


Figure 1

It is of interest to note that the number of CRNA's has actually remained relatively constant since 1983 with only a small increase in number over the past six years. In contrast the number of anesthesiologist continued to grow steadily until 1994 when that growth

Figure 2

appeared to level off. If the work force has leveled off and if there is a "shortage" of anesthesiologists, then the demand must have increased over the past several years. This may in fact be the case. Where could this added demand be coming from? There are several possibilities including 1) more surgery (in spite of promised reductions from managed care); 2) greater geographical dispersal of surgery (ie. office based anesthesia); 3) greater numbers of non-surgical procedures requiring anesthesia (ie. radiological procedures); and 4) other venues of practice (ie. pain management).



SUPPLY vs DEMAND

Over the years the number of anesthesiologists completing American training programs has varied (Figs. 2 & 3).⁶ At one point in the early 1990's there was concern raised that too many new anesthesiologists were being produced and that they would have difficulty finding work.² These largely political concerns translated ultimately into a decrease in the size and the composition of the resident applicant pool. Since the size of the work force depended upon how many anesthesiologists were leaving the practice and how many were starting practice, a shift in the total manpower pool could be affected by one or both of these factors. The ages of

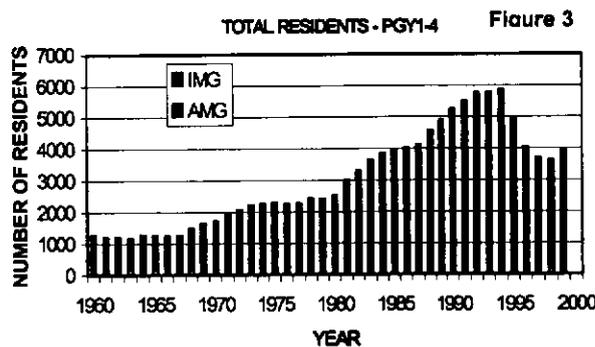
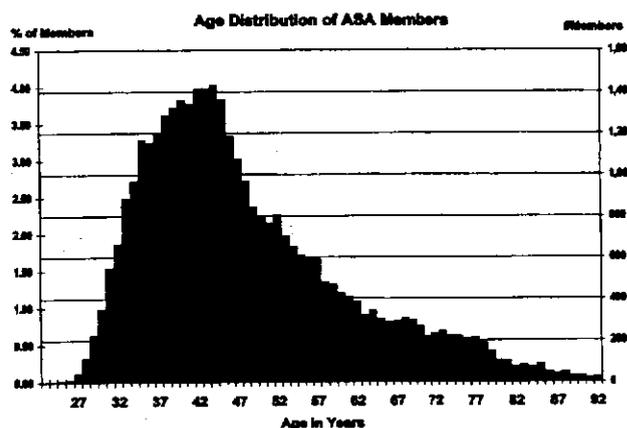


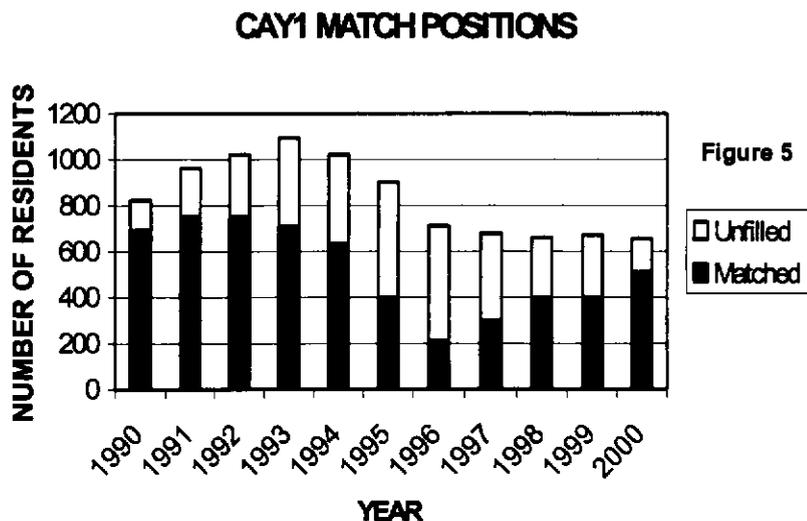
Figure 4



members of the ASA show that anesthesiologists have an average age of 45.⁶ The age distribution further shows that the curve is skewed to the left (Fig 4). Assuming that the

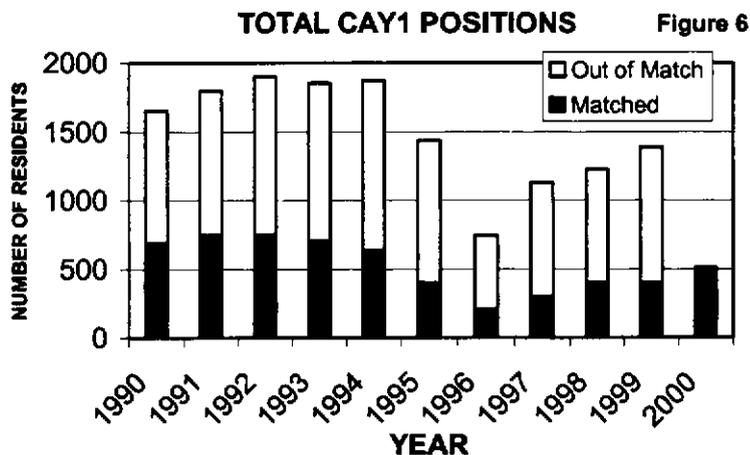
retirement rate is age related then we should expect to see a continued increase in the rate of retirement in the future. This appears to be occurring and is reflected in ASA membership according to Dr. Thomas Cromwell ASA Secretary.¹⁰ Dr. Cromwell notes that the retired category of ASA membership has increased at the expense of the active and resident members. Further the growth rate of the ASA has declined in the latter half of the 1990's from 600-800 per year (1990-1995) to 164 new members in 1999.¹⁰ If the rate at which anesthesiologists are leaving practice continues to increase, the question is what is the replenishment rate going to be?

In 1994, there was a dramatic decrease in the number of individuals in the residency application pool.³ As a result many residency match positions (both CAY1 and PGY1) were not filled (Fig 5 unfilled CAY1 match positions) although the majority of positions are filled each year out of match (Fig. 6). Still, the total



number of residents in training also declined (Fig. 3). At the same time we began to see an increase in resident attrition rate over the CAY1-3 training period (Fig 7). Some training programs were closed and most decreased the number of positions that they offered.

Many programs sought to meet manpower needs by having attendings provide care directly, or by hiring CRNA's. The overall effect was to decrease the total number of residents being trained to level similar to those seen in 1987 (Fig. 3). The passage of the



Balanced Budget Act of 1997, has the effect of capping the number of government funded residency positions. The long term effect on anesthesiology training programs is to cap

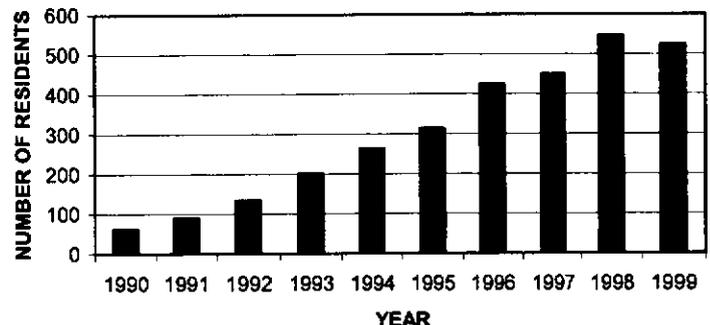
the capacity of our programs to a decreased number of graduates.⁴ The BBA also puts stress on academic anesthesiology programs that relied on residents as part of their provider manpower.

Because a number of training programs depended upon residents to provide much of the anesthesia services, when the applicant pool dropped precipitously resident slots were largely filled with international medical graduates (IMG) some of who have J1 visas (Table 1).³ Note that from 1995 to 1999 the total number of graduates not only reduced from 1,863 to 892, but the number of American medical graduates reduced from 1,547 to 544.

Graduating Year	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
AMG	1,179	1,324	1,372	1,388	1,512	1,455	1,547	1,358	1,101	792	544
IMG	102	100	152	171	206	217	316	339	347	308	348
TOTAL	1,281	1,424	1,524	1,559	1,718	1,672	1,863	1,697	1,448	1,100	892

In the latter half of the 1990's the number of international medical graduates was in the range of 300 to 350 thereby causing the percentage of IMG graduates to climb. No doubt many of these graduates encounter difficulties in remaining in this country

CAY3 RESIDENTS SELECTING FELLOWSHIP TRAINING Figure 8



due to restrictions on the J-1 visa and can not be seen as a means to replenish the work force. Additionally, the number of graduating residents opting for fellowship training has also seen an increase each year further slowing the replenishment rate (Fig. 8). It is not clear how many of these residents entering fellowship training are residents with visa problems. Pain management has become the most popular fellowship. How much time these practitioners will spend in OR anesthesiology practice is also not known. Since there are currently 227 anesthesiologists in pain fellow training, this may have a significant impact on manpower.¹¹

As the manpower pool fails to provide enough anesthesiologists nation wide, the law of supply and demand may begin to bid up compensation putting an additional burden on academic departments.⁸ Academic departments have traditionally paid lower salaries

while providing more time to pursue academic activities.⁷ Because of the demand for clinical productivity, time for non-clinical pursuits becomes harder to maintain. Faculty finding their academic life looking more and more like that of someone entirely in a private practice wonder why they shouldn't move away from the academic practice altogether.

THE FUTURE

There appears to be more interest today in anesthesiology by medical students, and the number of residents graduating each year is increasing. Although the number of graduates is still well below that of the early 90s and the number of AMG graduates will be no more than 811 in the graduating class of 2003. Table 2 presents the graduating class of 2000 and the current CA-3, CA-2 and CA-1 classes as of the summer of 2000. Note that the number of AMG

Current Year of Training	Recent Grads	CA-3	CA-2	CA-1
Graduating Yr	2000	2001	2002	2003
AMG	392	471	632	811
IMG	527	634	707	642
TOTAL	919	1105	1339	1453

graduates was only 392 in the summer of 2000 and progressively increases to 811 by 2003 which is only 54% of AMG graduates of 1993. The overall class size grows from 919 to 1,453 during the next three years. Although some may predict that 1,453 graduates is sufficient to meet the nations needs, again it is unclear how many of the six to seven hundred IMG graduates will be able to stay in this country. The number of AMG, IMG and total graduates are presented graphically in figure 9.

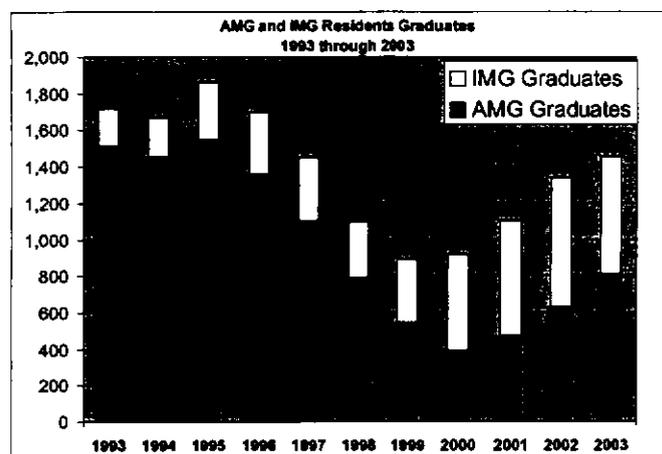


Figure 9

At the same time two major factors are likely to increase demands for anesthesiologists currently in practice: increased demand for services and increased attrition rate of anesthesiologists. The demand for anesthesia services will most likely parallel the number of surgical procedures performed each year in this country. Although some may argue this is a conservative estimate due to the number of requests for "off site" anesthesia for diagnostic procedures and the number of practitioners going into pain management. It is difficult to determine how many surgical procedures are performed in this country each year. The US Department of Health and Human Services provides estimates of inpatient

and outpatient cases from National Health Surveys. Between 1994 and 1996 the number of surgical procedures increased approximately 5.1% per year, totalling 71.9 million procedures per year in 1996. Again this does not include off site anesthetics for non-surgical procedures and office based anesthesia.^{12,13,14}

The attrition rate of anesthesiologists is likely to increase over the next decade due to the age distribution of our current practitioner as discussed earlier and illustrated in Figure 4. It is therefore likely the demand will continue to grow for anesthesiologists for the foreseeable future. The challenge for academic programs is to be able to compete successfully for faculty who must provide cost effective anesthesia care, train future anesthesiologists and advance our knowledge.

Section II - Medicare Reimbursement: Past, Present and Future

In 1965 Medicare was instituted as a social program to provide medical care for the elderly, primarily patients over 65 years of age. Physician reimbursement for services is part of Medicare and is considered Part B. (Part A reimburses the hospitals for services provided Medicare recipients.) Determination of physician payments has evolved over time. Anesthesiology services are computed differently than all other physicians. Anesthesiologists are reimbursed with a time-based methodology whereas other physician services are based on a resource based system.

The "resource-based" system was developed by Hsiao and other health policy academicians during the late 1970s and early 1980s. In 1992, the Health Care Financing Administration (HCFA) moved to the new resource-based fee schedule and moved away from the historical physician charges. The new system was labeled the Medicare Fee Schedule (MFS). In an effort to standardize fee payment HCFA developed a "Resource Based Relative Value System" (RBRVS) which is based on "Current Procedural Terminology" (CPT) codes which are a listing of physician services (surgery and anesthesia CPT codes are different, even for services on the same patient.) There are 8,000 CPT codes in the MFS and 250 Anesthesia CPT codes.

There are three elements which make up the unit value of this resource-based methodology: 1) physician work, 2) practice expense and 3) professional liability costs. The purpose in creating this system was to establish proportional weights for all physician services that could then be converted into reimbursement levels. Each CPT code is reimbursed the same regardless of the medical specialty. The RBRVS-reimbursed procedures are paid at a predetermined fee calculated from the RVU. Reimbursement is initially determined under the fee schedule by multiplying the total relative value units for a procedure by a "conversion factor." The conversion factor (CF) is adjusted each year to account for inflation and other factors. There is also a geographic adjustment (GPCI) that is designed to take into account the regional differences in cost of living around the country.

(RVU X GPCI X CF)

Equation 1

where: RVU= relative value unit
 GPCI= geographic practice
 CF= conversion factor

The 1999 (CF) dollar amount for all services except anesthesia codes was \$34.73

HCFA is advised on the appropriate relative value setting of the RBRVS by the American Medical Association's Relative Value Update Committee (RUC), and this committee is made up of 28 members, each representing major specialty societies including the American Society of Anesthesiologists (ASA). The majority (about 90%) of recommendations regarding RBRVS made by RUC are accepted by HCFA.^{15,16}

Anesthesiology does not participate in the RBRVS reimbursement methodology and is the only major medical specialty that does not. The reason for this is that the American Society of Anesthesiologists (ASA) has lobbied successfully to have anesthesiologists be reimbursed based on time and complexity of the case using the ASA Relative Value Guide (RVG) of 1988. In 2000, the anesthesia conversion factor used in calculating the reimbursement for Medicare cases was \$17.77. The portions of this anesthesia conversion factor are now represented by physician work (74%), practice expense (19%) and malpractice liability cost (7%).^{16,17} To calculate anesthesia reimbursement, the basic anesthesia RVUs are multiplied by time units and the conversion factor to compute anesthesiologists reimbursement. If an anesthesiologist is supervising a CRNA or a resident, then the anesthesiologist's fee may be reduced. The formulas used in computing the anesthesiologist's professional reimbursement by Medicare are listed below:

((Time Units + RVU) X CF)

Equation 2

where: Time units (at 15 minute increments)
 RVU = ASA relative value genda represents base units
 CF = conversion factor (\$17.77)

Medicare has successfully reduced anesthesia reimbursement over time through several mechanisms incorporating the ASA's (RVG) methodology. It put a cap on ASA base unit reimbursement for cataract surgery in the 1980s. In the mid 1990s, it introduced a four-year phase in of reimbursement for concurrent CRNA supervision so that at the end of the

process the anesthesiologist would get 50% of the Medicare fee when supervising a CRNA. (See below)

Attdg to Resident Case Ratio	Medicare Modifier	Attending Anesthesiologist Reimbursement
1 to 1	AA	Full Medicare Allowable per case
1 to 2	QK*	Half Medicare Allowable per case*

Effective January 2000 modifier AE has been discontinued; QK is to be used unless otherwise instructed by Medicare carrier.

Attdg to CRNA Case Ratio**	Medicare Modifier	Attending Anesthesiologist Reimbursement
1 to 1	QY	Half Medicare Allowable per case

Attdg to Res or CRNA Case Ratio**	Medicare Modifier	Attending Anesthesiologist Reimbursement
1 to 2	QK	Half Medicare Allowable per case
1 to 3	QK	Half Medicare Allowable per case
1 to 4	QK	Half Medicare Allowable per case
Greater than 1 to 4	AD	Three base units per case; add 1 unit if attending presence is documented at induction

**When a resident and CRNAs are supervised, modifier QK is to be used for multiple concurrent procedures - not to exceed four. Reimbursement follows QK pattern.

It has been recently estimated by the ASA that Medicare anesthesiology fees compared to other specialists are undervalued by as much as 40% using evaluation and management (E&M) codes for comparison.¹⁸ Using a different analysis at Duke Medical Center, ie. Medicare versus HMO reimbursement for common anesthesia CPT services compared to other specialists common services was 56% undervalued.¹⁹ Under-valuation of anesthesiology services causes another, related problem - "Medicare multiples." Integrated professional group practices are now using a methodology to disburse or to set contract fees according to Medicare multiples. Because Medicare undervalues anesthesia services, when a Medicare multiple is used for all specialties, then anesthesiology will have much lower compensation than other specialists. To correct for this error, a factor of 1.8 should be used in the Medicare multiple in calculations of anesthesia contract reimbursement. For example, if a group contract is negotiated at 1.2 of Medicare then anesthesiology should receive 2.2 of Medicare (1.8X1.2).

Marshall and Jablonski have developed a method of converting anesthesia RVUs to RBRVUs for business applications within their own practice plan.¹⁵ They have found that this is feasible and most accurate using time units derived from one's own institution. Their methodology is attractive since most of the variables in the formula come from HCFA, and one ends with RVUs that can be compared among specialists. The formula is:

Equation 3

Imputed work RVUs = $(((\text{base} + \text{time}) \times \text{anesthesia CF}) / \text{surgical CF}) \times \text{specialty weight}$

where: base = base units per anesthesia CPT code

time = time units based on 15-minute increments

(best to use institutional data on times)

anesthesia CF = 1994 national anesthesia conversion factor (CF) of \$15.32

surgical CF = 1994 national surgical conversion factor of \$39.45

specialty share weight = anesthesia specialty share weight for work in 1994 or 0.695

MEDICARE REIMBURSEMENT OF HOSPITAL SERVICES

When Medicare was established in 1965 it was decided that a portion of the hospital compensation should defray the extra costs that resident physicians added to hospital costs and as well as the additional overhead costs that the presence of residents added to hospitals. It has long been known that hospitals with teaching and research programs are more expensive in the delivery of health care than hospitals without these additional missions. It likewise has been recognized that teaching hospitals often have a disproportionate share of non-reimbursed patient care loads for which they should receive some compensation if they are to remain viable providers of care for Medicare patients.

MEDICARE DIRECT GRADUATE MEDICAL EDUCATION (DGME) PAYMENTS

Medicare makes explicit payments to teaching hospitals for a portion of the added costs incurred with health professions graduate education programs. These added costs are for the stipends and fringe benefits of residents, salaries and fringe benefits of faculty who supervise the residents, and other direct costs. From 1965 until the mid 1980s, Medicare paid its share of DGME based on "Medicare-allowable" costs, which was an open-ended

reimbursement that allowed (encouraged) hospitals to increase the size of residency programs.

In April 1986, Congress passed the Consolidated Omnibus Budget Reconciliation Act (COBRA) which uncoupled the relationship between direct costs and DGME payments. It did this by paying each hospital a portion of its per resident amount based on the DGME costs incurred by the hospital during a base year period and divided by the number of residents counted in the base year (not the current year.) Also Medicare limited the number of years that it would pay 100% of resident costs. The number of years is specialty specific: it is set at the number of years that it takes to become board-eligible or a maximal number of 5 years, whichever is lowest in each specialty. Medicare will only pay 50% of resident costs for residents that do not meet these time requirements. Also, beginning in 1993 hospitals have been paid slightly more for primary care residents and slightly less for specialty residents including, of course, anesthesiology. At present (because of the Balanced Budget Act of 1997 – see below) each hospital is effectively limited to the number of residents per hospital that they had in December 1996. There were a total of 3458 (CA-1 to CA-3) residents in anesthesiology in 1996, 32% of whom were international medical school graduates.³

DGME is paid based on a fixed rate per resident at each hospital under the following formula:

DGME = Per-resident rate X number of FTE residents X Medicare share Equation 4

where: “Medicare share” of resident costs is calculated as the number of Medicare patient days divided by the total number of in-patient days that a hospital has per year.

per-resident rate is hospital-specific based on 1985 hospital-specific GME costs that are adjusted for annual inflation and 1985 FTE residents.

FTE count is determined from eligible resident rotation schedules. Some residents and rotations are excluded in calculation of the count.

This formula does not make it clear how hospitals are to reimburse individual Departments or pay directly the physicians for whom the hospitals receive some payment in the form of DGME. It is likely that some hospitals do not directly pay clinical departments. It is also not clear by what formulation disbursements are made in those hospitals that do reimburse departments for the clinical teaching of the faculty. For anesthesiology it is tricky, although anesthesiologists spend a great deal of their clinical time working with residents and presumably much of this time is spent in teaching, HCFA forbids payment for education and simultaneous clinical care, so called "double-dipping." Nevertheless, hospitals should be paying departments some portion of their DGME for physician teaching of the residents.

MEDICARE INDIRECT MEDICAL EDUCATION (IME) PAYMENTS

In 1983 with the implementation of the prospective payment system (PPS), a "medical education" label was implicitly put in congressional language that added an adjustment for indirect medical education costs in teaching hospitals. This concept and payment was called the "indirect medical education adjustment" for hospitals receiving Medicare payment. The original IME PPS payment was 11.59% for each 10 percent increase in the intern and resident-to-bed ration (IRB) in 1983. The IME has been steadily recalculated and reduced over time. It fell to 8.1% in 1986, and with the Omnibus Budget Reconciliation Act of 1987 fell to 7.0% where it remained until 1997 with passage of the Balanced Budget Act (BBA - see below). The BBA has scheduled sequential decreases in the IME of 28.75% over a four-year period. The IME, therefore, was reduced from 7.0 percent to 6.5% in 1999 and is to be lowered to 6.0% in FY2000 and 5.5% in FY 2001. The recently passed Balanced Budget Refinement Act (BBRA) deferred the last two years of the planned IME reduction until 2002.

Equation 5

The IME formula adjustment to DRG payments is calculated:

$$\text{IME} = (((1 + \text{resident-to-bed ratio})^{.405}) - 1) \times \text{payment factor} \times \text{Medicare DRG payments}$$

where: The resident-to-bed ratio is the ratio of FTE residents to available beds.

The payment factor is a factor that is set by Congress and is currently 1.60.

This money is not specifically set for the payment of clinical faculty, but recognizes the added costs that interns and residents bring to a hospital. Because so many interns and residents are concentrated in the large teaching hospitals, primarily in the Northeastern

part of the country, about one-fifth of all teaching hospitals train two-thirds of all residents and received two-thirds of all IME funds. It is obvious that these hospitals are losing the greatest amounts of money as the IME is being scaled back. The Medicare Payment Advisory Commission (MedPAC) estimated that IME payments were \$4.6 billion FY 1997. One may conclude then that the BBA as it scaled back the IME Medicare payments to teaching hospitals has indeed helped the country amass the enormous budget surplus reported in FY 2000.

MEDICARE DISPROPORTIONATE SHARE (DSH) PAYMENTS

In 1986, using the Tax Equity and Fiscal Responsibility Act (TEFRA) as a vehicle and after passing COBRA, Congress recognized the fact that the teaching hospitals cared for uninsured patients and that this was putting financial stresses on the teaching hospitals. A Medicare Disproportionate Share (DSH) payment adjustment was added to compensate hospitals for caring for the low-income patients. It is also believed that DSH preserves access to care for Medicare and other low-income patients. The congressionally mandated program is an explicit adjustment for hospitals that serve a large share of low-income patients and was incorporated into the PPS in May 1986. In 1990 legislation about \$1 billion was added over a five-year period through changes in the DSH formulae. In 1997 about 40 percent of all PPS hospitals were eligible for DSH payments amounting to \$4.5 billion. More than 95% payments go to urban hospitals, and teaching hospitals received \$3 billion DSH payments in 1997 or about two-thirds of all DSH payments.²⁰ The BBA reduces DSH payments by 5%, with the reduction to be implemented in 1% increments between fiscal years 1998 and 2002.

The DSH Payment Methodology is calculated as a percentage add-on to the basic prospective DRG payment. The amount of the DSH payment that a hospital receives is determined by a complex formula in which each hospital's DSH percentage is calculated. The BBA requires a new uniform formula be derived. This now requires a single minimum threshold for low-income market share. The 1999 BBRA stopped the decrease and will restore DSH prior cuts in 2003. To be eligible hospitals are required to provide new data about the amount of uncompensated charity care they provide by October 2001.

THE BALANCE BUDGET ACT (BBA) AND THE BALANCED BUDGET RELIEF ACT (BBRA)

Since the inception of the Medicare program in 1965, no congressional action has had more devastatingly negative financial impact on teaching hospitals than the passage in 1997 of the Balanced Budget Act (BBA). Medicare and Medicaid planned reduced spending of \$116 billion (Medicare) and \$15 billion (Medicaid) from 1998 to 2002. Teaching hospitals bear the brunt of these changes, although all hospitals are affected. (Figure 10) The more residents a hospital has, then the more severe the cut - thus, the larger teaching hospitals are hit the hardest with the decreases in IME, DSH and DGME provided in the BBA. The effect of teaching hospital size is illustrated by these AAMC data: On average, all hospitals will lose 0.5% in operating payments per case. Teaching hospitals with 100 or more residents will lose 1.5%, other teaching hospitals will lose 0.6%, and non-teaching hospitals will gain 0.2%.²¹ Because of the obvious but unintended financial disastrous consequences of the BBA, the Balanced Budget Refinement Act (BBRA) was passed in November 1999 which slows the implementation

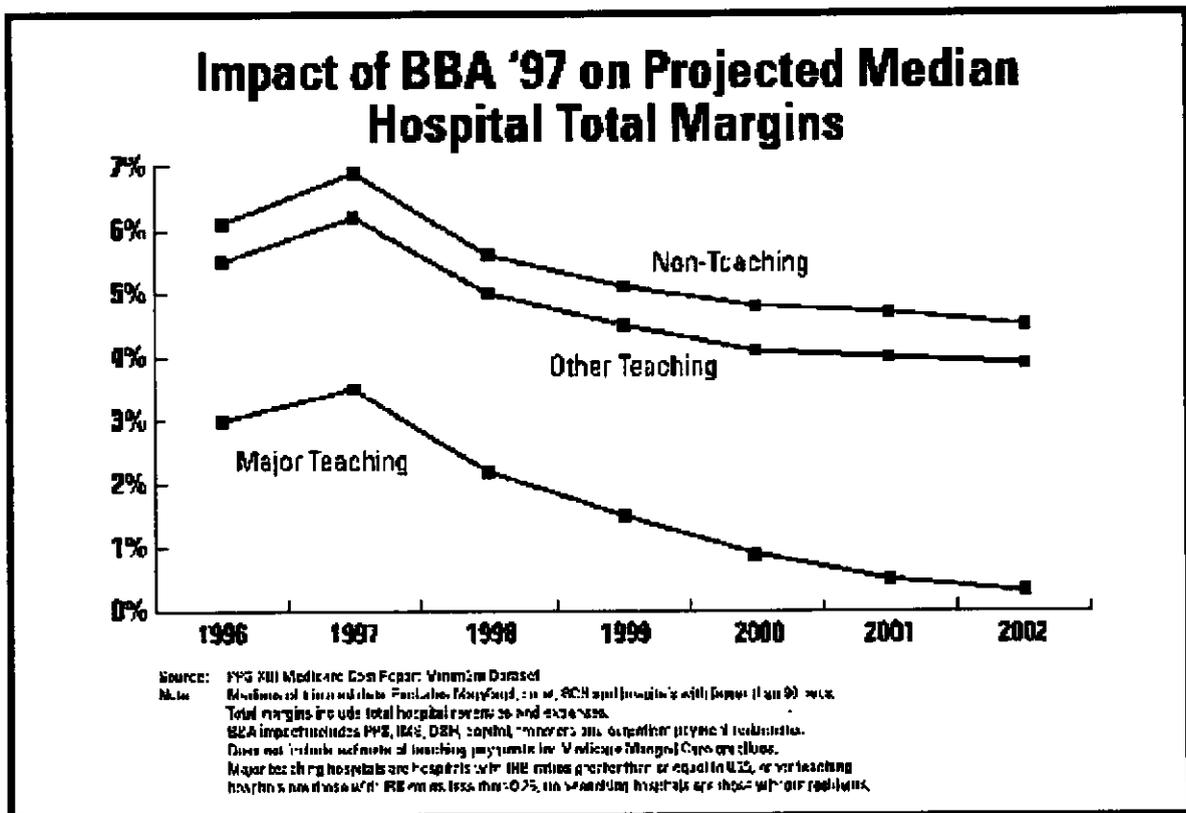


Figure 10. Numbers on the Y-axis are the financial margins (profit) and the X-axis shows the year and the affect that the Federal Balanced Budget Act will have on academic teaching hospitals. Hospitals with the most residents are by definition the largest teaching hospitals and

will suffer the greatest loss of indirect medical education monies from the withdrawal of medicare subsidies. This is denoted by the greater downward slope of this category of hospital. Hospitals with negligible teaching are less adversely impacted. Major Teaching Hospitals have an intern and resident to bed ratio of 0.25 or above. Other Teaching Hospitals have an intern and resident ratio of less than 0.25. Non-Teaching hospitals do not have interns and residents. (Data from Association of American Medical Colleges, Fact Sheet [23])

of the BBA and restores some of the losses already experienced by academic hospitals. In this congressional bill, \$17 billion was restored. Since the BBRA provides only partial relief (amounting to about 10% restoration of the net loss in the BBA) the Association of American Medical Colleges (AAMC) and the American Hospital Association (AHA) have both independently estimated that teaching hospitals are on the brink of collapse. At the end of 2004, nearly 60% of the nation's hospitals will not be able to cover their costs when treating Medicare patients.²² The AAMC has estimated that the typical member teaching hospital will lose over \$40 million between 1998 and 2002, even with the enactment of the BBRA. Total hospital margins will continue to decline by over half from 4 percent in 1998 to 1.6 percent in 2002.^{23,24} This has obvious impact on a hospital-based academic department like anesthesiology.

Aside from the important financial consequences of the BBA, there are some specific changes that the legislation makes in the calculation of DGME and IME payments to hospitals. Beginning FY 2001 each teaching hospital will receive DGME reimbursement based on its position within the range of teaching hospitals throughout the country. Hospitals with per resident weighted costs, adjusted for its specific geographic locality, of between 70% and 140% of the national reimbursement will receive inflation-adjusted, increased payments per resident each year. Hospitals whose costs are below the 70% floor will be increased to the 70% rate, but those above 140% will be capped at their current reimbursement level for FY 2001 and 2002, and they will be ratcheted down for each of the next three years at a 2% rate. Individual hospitals, thus will be more or less affected by the BBA based in part on their historical reimbursement compared to the entire national experience. According to the AAMC predictions, increased DGME payments will occur for approximately 265 hospitals and a payment freeze for approximately 119 hospitals. Hospital-specific estimates can be found at www.aamc.org/coth/dgme.

In addition to the DGME hospital specific changes mentioned above, the BBRA is predicted to provide \$600 million to teaching hospitals in IME, \$100 million in DSH payments, and \$40 million in GME to independent Children's hospitals.

The BBA also placed limits on the number of full-time equivalent (FTE) residents that hospitals can count for DGME payments and directed that the number of resident FTEs in 1996 was the maximal number that would be fully compensated. A three-year rolling average not to exceed the 1996 must be submitted by each hospital for DGME payment recalculations each year.

Clearly the effect of the BBA has been to significantly reduce hospital revenues. Its effect on resident numbers has also decreased the availability of residents as clinical providers. Recent adjustments to the BBA have not reduced its effect, but just delayed the onset of more severe reductions. One can not only hope that a continued strong economy will lead to greater pressures to possibly curtail the implementation of subsequent reductions or possibly even reverse previous reductions to teaching hospitals revenues.

Section III - Published Data: AAMC, MGMA & SAAC

Every year, the Medical Group Management Association (MGMA) publishes a report titled: "Physician Compensation and Production Survey," which provides national averages on salaries, costs, productivity, and working hours for physicians of all specialties. These data include practitioners of all types, but are heavily weighted towards private practice because of the number of respondents. In 2000 they have also published a "Faculty Compensation and Production Survey," showing data from academic departments. In addition, both SAAC and the AAMC publish average compensation data for academic physicians in all specialties. SAAC provides salary data by US region (West, Northeast, South, Midwest), while AAMC provides only national medians. Here we shall extract some highlights of the most recent reports of all three organizations, in order to facilitate comparisons of productivity, costs and salaries between different anesthesiology departments and different specialties.

COMPENSATION, CHARGES, OVERHEAD

Table 3 shows median values of both compensation and charges for anesthesiologists and "all specialists" from 1994 through 1998.

The first four rows are from the MGMA 1999 report, reflecting mostly private practice data.⁸ The

	1994	1996	1998	1999	change/yr
Private-Comp	\$244,600	\$237,749	\$250,200		0.57%
Charges	\$475,303	\$515,160	\$633,591		8.32%
Comp.- all	\$212,183	\$221,544	\$231,993		2.34%
Charges - all	\$560,000	\$654,021	\$724,275		7.33%
Faculty-Comp		\$167,839	\$171,774	\$177,161	1.85%

fifth row comes from the 2000 MGMA report on faculty practice, and represents overall averages of academic anesthesiology salaries.⁷ The right-hand column is the average percentage change for each year of the interval covered.

The interesting trend for this four-year period is that anesthesiologists' compensation was nearly flat, while our charges grew by 8.3% per year. The growth in charges for "all specialties" was similar (7.3%), but the compensation increase was much greater (2.34% per year). Does this mean that anesthesiology charges increased only because we raised our rates, or are we actually producing more work and being paid less for it? We do not

see in these data the sharp upturn in faculty salaries that we are expecting to see in year 2000 data. It is also worth mention that in the MGMA faculty report only 30 of 111 departments responded to the survey.⁷

The MGMA 2000 report also found that "base compensation" represents a median of 82% of the total compensation for academic anesthesiologists. This implies that 18% of our compensation is "at risk" in the form of incentives or bonuses, which are not guaranteed income. This fraction of at-risk compensation is among the highest in the specialties. There are few earlier data with which to establish trends of this incentive fraction.

For entry-level anesthesiology faculty, the MGMA 2000 Report quotes a mean of \$139,299, and the SAAC 1999 Survey gives a national median of \$141,643.

We are all well aware of the large regional variations in academic salaries, shown in the 1999 SAAC Salary Survey report.²⁵ MGMA provides similar comparisons for median private practice anesthesiologist salaries, showing somewhat different trends:

Eastern: \$236,000 Midwest: \$311,165 Southern: \$305,800 Western: \$229,524

Compare these numbers with the SAAC 1999 Survey "stipend only" median for an Associate Professor of Anesthesiology:

Eastern: \$210,045 Midwest: \$222,341 Southern: \$196,031 Western: \$180,314

Two features of this comparison are striking. (1) The regional highest versus lowest variation in private practice is 35%, while in academics it is only 23%. (2) There is not a large difference between an Associate Professor and a private practitioner in the Eastern region, especially if we add the value of the fringe benefits. (SAAC Eastern Assoc. Prof., with fringe = \$253,720.) It is possible that the MGMA numbers, based upon 1998 data, underestimate today's private practice salaries. Another way to look at regional variation is by the ratio of academic (Associate Professor) to private practice salaries:

Eastern: 0.89 Midwest: 0.71 Southern: 0.64 Western: 0.78

This ratio is highest in the East and lowest in the South.

Table 3 also shows that the compensation-to-charges ratio (1998) for all anesthesiologists is 0.39 (c.f. 0.32 for "all specialists"), but the MGMA 2000 Report shows that this ratio for academic anesthesiologists is 0.25. That is, private anesthesiologists have lower overhead expenses than other specialists, but academic anesthesiologists do not. Table 4, also derived from 1998 MGMA data, shows average overhead rates for various specialties.

Table 4 shows that anesthesiology has by far the lowest average overhead rate of all specialties, at about 10%. Of course this is a rate that reflects mostly private practice, and academic overhead rates are in the range of 10 to 30% depending on the type of system model, Section 4. Nevertheless, the data clearly illustrate that overhead rates are different among the various specialties. Even in academic medicine, anesthesiology should not have the same overhead burden as, for example, family medicine. Solid data for academic overhead rates are hard to obtain and there is wide variability depending on the structure of the academic practice, assessment rates, etc. However data from Section 4 demonstrates that in general, training departments of anesthesiology have higher rates than their community practice counterparts.

Table 4: % of practice income used for MD expense vs overhead		
Physician Specialty	Distribution of practice income	
	% MD Compensation	% Overhead
Anesthesiology	90%	10%
Family Medicine	45%	55%
Internal Medicine	50%	50%
Cardiology	58%	42%
Dermatology	50%	50%
Endocrinology	50%	50%
GI	50%	50%
General Med	50%	50%
Hem/Onc	50%	50%
Inf Disease	50%	50%
Nephrology	50%	50%
Pulmonary	50%	50%
Rheumatology	50%	50%
Neurology	55%	45%
OB/GYN	50%	50%
Ophthalmology	44%	56%
Orthopedics	57%	43%
Pathology	72%	28%
Pediatrics	48%	52%
Allergy/Immun	47%	53%
Pulmonary	47%	53%
Neonatology	47%	53%
Hem/Onc	39%	61%
Cardiology	58%	42%
General Peds	47%	53%
Critical Care	47%	53%
Psychiatry	60%	40%
Radiology	72%	28%
Radiation Oncology	72%	28%
Surgery	64%	36%
Vascular Gen	75%	25%
ER Med	64%	36%
ENT	64%	36%
Neurosurgery	65%	35%
Plastics	64%	36%
Urology	49%	51%
Cardiothoracic	69%	31%
Gen Sur/Trauma	64%	36%

Source: MGMA Cost Survey, 1997

HOURS WORKED, PRODUCTIVITY

Interestingly, the MGMA report does not provide data for average hours worked by anesthesiologists, but it does for all other specialties. Since we have a good idea of our own work hours, here are some values of total weekly professional hours for other specialties.

Specialty	25%-ile	Median	75%-ile
Family Practice	40	45	50
Internal Medicine	40	50	55
Pediatrics	40	45	52
Emergency Med.	35	37	40
Radiology	40	47	53
OB-Gyn	40	52	60

Another way of comparing time worked is also presented by the MGMA data.

Table 5b presents the percent of faculty who fall within the various thirds of percent billable time. Although this is not broken down by specialty, note that 52% of academic faculty spend between 0 and 66% of their time in billable activities, Table 4b

% Time Billable	% Faculty in this Range
0 to 33	21
34 to 66	31
67 to 100	48

Section IV - SAAC/AAPD Financial Survey Results

In February 2000, a financial survey was sent to SAAC/AAPD member institutions to determine the current status of our training departments with respect to personnel, budgeted support, reimbursement, revenue and expenses. Appendix 1 (SAAC/AAPD Financial Survey). Although our training programs vary substantially due to institutional and geographical differences, there are significant areas of commonality. From a financial perspective, our departments can be divided into three categories. The first category are those departments in academic medical centers with medical schools. They are financially responsible for their revenue and expenses. Those departments in general receive support funds from the medical school and hospital and in turn pay taxes and group practice overhead expenses. This group will be referred to as the academic medical center model (AMC Model). The second group are departments which are more fully integrated into hospitals or group practices in which they are budgeted within the overall finances of the institution. For these departments it is not possible to fill out much of this survey with respect to revenue and expenses for all the departments activities are expense based relative to their budget. The second group will be referred to as the budgeted department model (Budgeted Model). In the third group, the departments are almost completely independent with respect to their finances, more analogous to private practice departments. They pay little or no taxes and in turn receiving little or no support from the hospitals. We will refer to this third group as the Independent department model (Independent Model). In the following report we will present overall data and group specific data for each of these models.

RESPONSE RATE

The survey in Appendix 1 was distributed to 113 SAAC/AAPD Institutions and an additional 29 AAPD programs by mail with follow-up reminders by e-mail, fax and telephone requests. A 80% response rate was achieved from the SAAC members (90/113) and a 34% response rate from AAPD members (10/29). Two departments reported that they no longer had residencies and therefore were excluded from this survey analysis. 17 surveys were returned with insufficient data to be included in the analysis leaving a final usable response rate for SAAC member departments of 66%, AAPD of 21%, with an overall response rate of 56%. This compares very well with the response

rates from the MGMA reports of 25% and 31% for their academic practice and overall physician surveys respectively.^{7,8}

DEMOGRAPHICS, PERSONNEL & INSTITUTIONAL SUPPORT

The overall demographic data are presented in Table 6. On average, our programs have 36 anesthetizing locations (23% of which are non-OR locations) which results in 0.8 locations per faculty FTE. We average 19,929 cases per year or 554 per faculty member. 69% of our departments run pre-op clinics and these departments see approximately 37% of their patients in those clinics. We also manage chronic pain clinics and acute pain services, Table 6. 41% of our

	Mean	Standard Deviation
# ORS	28.3 N = 80	17.8
# Other Anes. Locations	7.9 N = 76	8.0
# of Cases with Anes. Per Yr	19,929 N = 79	12330
# OB Delivers w/ Anes. Per Yr	2842 N = 72	3006
# Pain Clinic Visits Per Yr	4308 N = 74	3277
# Pre-Op Clinic Visits Per Yr	7431 N = 55	5382
# FTE's	36 N = 80	21.5
# of Full Time Research	3.5 N = 62	3

institutions manage the anesthesia service at Veteran's Administration Hospitals and 38% of those do so at a financial deficit to the department which averages \$326,644 year or

VA Staffing Responsibility	Yes = 41% N = 32	No = 59% N = 46
If yes, Financial Deficit? N = 25	Yes = 38% N = 12	No = 62% N = 20
If Financial Deficit, How much? N = 10	Mean Mean/FTE	\$326,644 \$9,129

\$9,129 per FTE, Table 7.

Our faculty spend approximately 69% of their time clinically, 17% in teaching assignments, 8% research and 7% administration, Table 8. As one might expect, our faculty spend more time providing clinical service when compared to the average academic faculty for all specialties, Table 5b, Section 3.

	Mean	Standard Deviation
% Clinically	69% N = 80	17
% Teaching	16% N = 80	12
% Research	8% N = 79	7
% Administration	7% N = 78	4
*Note: Not all departments responded in all categories.		

Our teaching hospitals receive payments from Medicare and Medicaid and in some instances third party carriers for the direct and indirect expenses of educating residents, as described in detail in Section 2. The Balanced Budget Amendment of 1997 has reduced and limited the reimbursement for these training expenses and has never paid for non-ACGME approved fellows. Table 9 presents data regarding the expenses for these trainees' salaries. In no department's surveyed were all of the resident's salaries paid for from departmental funds. In 50.6% the department paid for no resident's while in the remaining 49.4% the department paid for some residents. It should be noted that

governmental payment of directs and indirects is proportionate to the patient mix of that hospital, that is, if the hospital has 30% Medicare patients, Medicare will pay 30% of the direct and indirect payments to that institution.

Table 10, presents the data of non-ACGME approved fellows (cardiac anesthesia, neuro anesthesia, obstetrical anesthesia and research). 57.5% of our programs have an average of 4.4 non-ACGME fellows. As one

might expect, 54.3% of non-ACGME approved fellows (research and clinical) are paid for by the departments completely while 21.7% of departments pay for some and 23.9% pay for none, Table 10.

85% of our programs employ CRNA's, 44.1% of which are paid for totally by the department (averaging 14.6 CRNA's per department) while 33.8% are paid for totally by the hospital (averaging 23.6 CRNA's per department). Of the departments which split the

	Department N = 79 Total	Hospital N = 79 Total	Medical School N = 79 Total	Other N = 79 Total
Pay for All	0% n = 0	44.3% n = 35	2.5% n = 2	1.3% n = 1
Pay partially	49.4% n = 39	49.4% n = 39	8.9% n = 7	19% n = 15
Pay for none	50.6% n = 40	6.3% n = 5	88.6% n = 70	79.7% n = 63

	Department Pays N = 46	Hospital Pays N = 46
Pay for All	25/46 = 54.3% n = 25	7/46 = 13.2% n = 7
Pay partially	10/46 = 21.7% n = 10	4/46 = 8.7% n = 4
Pay for none	11/46 = 23.9% n = 11	35/46 = 76.1% n = 35

Note: • 34/80 Institutions do not have a Non-ACGME Approved fellowship program.
• 46/80 Institutions have an average of 4.4 Non-ACGME Approved fellows.
* Medical School & Other do not pay for Non-ACGME Fellows

CRNA funding between hospital and department funded, the average split is 53% department, 47% hospital, Table 11.

	All Institutions N = 80 N = 68 CRNA N = 12 no CRNA (15%)	# of CRNAs
100% Funded by the Dept	30/68 = 44.1%	14.6
100% Funded by the Hospital	23/68 = 33.8%	23.6
Percent Partially Funded	15/68 = 22.1%	

Partially Funded Breakdown	Percent	# of CRNAs
% Funded by Department	53%	17.2
% Funded by Hospital	47%	21.7

The data regarding hospital/medical school support for clinical, administrative and teaching activities are presented in Table 12. Some institutions receive an overall support budget which is not itemized, therefore the funds allocated to each area of potential support is the average number of dollars for which those itemized data were provided. Overall our departments receive an average of \$1,235,474 per year which is \$34,319 per faculty. As one might expect the AMC Model receives substantially more support than the independent model (\$34,987 per FTE vs \$17,034 per FTE). But as it will be noted on the expense side, the AMC department pays nearly twice the overhead rate to their institutions.

	OR Mgmt*	OB*	ICU*	Pre-Op*	General Administrative*	Other*	Total Hospital Support	Support Per FTE
All Institutions N = 66	65% \$ 225,073	18% \$194,046	36% \$212,226	30% \$107,899	61% \$431,841	61% \$798,394	100% \$1,235,474	\$34,319
AMC Classified N = 59	70% \$225,849	20% \$194,046	41% \$212,266	32% \$111,735	61% \$455,919	61% \$863,500	100% \$1,329,510	\$34,987
Independent Classified N = 7	29% \$201,150	0%	0%	14% \$35,000	57% \$215,138	57% \$212,442	100% \$442,884	\$17,034

* Numbers represent those that reported itemized breakdowns

REIMBURSEMENT, REVENUE & EXPENSES

Table 13, Reimbursement, presents payor mix and collection rates. On average our institutions charge \$62.00 per unit and have an average collection rate of 42.5% or a net collections of \$26.35 per unit.

Payor	Mean
Medicare	8.5%
Medicaid	8.6%
HMO	22.6%
Insurance	27.4%
Self Pay	12.5%
Other	20%
Overall Collection Rate	42.5%
Full amount of Charge per unit (\$)	\$62.6

Table 14 presents the itemized revenue by percent of total income for the AMC and Independent Models and Table 15 presents the itemized

	Clinical Care	Research	Teaching & Administration	Endowment & Investments	Other	Mean Total Revenue per Institution	Revenue Per FTE
All Institutions N = 66	Mean 79% n = 66	Mean 6% n = 57	Mean 10% n = 61	Mean 2% n = 47	Mean 7% n = 46	Mean n = 66 \$14,952,350	\$407,420
AMC Classified N = 59	Mean 78% n = 59	Mean 6% n = 54	Mean 10% n = 56	Mean 2% n = 45	Mean 7% n = 40	Mean n = 59 \$15,458,319	\$403,611
Independent Classified N = 7	Mean 91% n = 7	Mean 1% n = 3	Mean 4% n = 5	Mean 3% n = 2	Mean 6% n = 6	Mean n = 7 \$10,687,754	\$411,067

expenses as a percent for those models. The financial data for the Budgeted Model

department is incomplete and less meaningful so it is not presented. These data are available in the appendix. As noted in Section III,

	Total Overhead	Compensation	Research	Other
All Institutions N = 65	Mean 19% n = 65	Mean 69% n = 65	Mean 4% n = 48	Mean 6% n = 58
AMC Classified N = 58	Mean 20% n = 58	Mean 68% n = 58	Mean 4% n = 45	Mean 6% n = 52
Independent Classified N = 7	Mean 10% n = 7	Mean 80% n = 7	Mean 3% n = 3	Mean 6% n = 6

anesthesiology practices have significantly lower practice expenses then other specialty practices. This survey for the departments that itemized their expense rate, the combination of taxes to deans, universities and presidents, overheads - rent, etc. and group practice overheads including billing and malpractice average 20% for the AMC Model and 10% for the Independent Model, Table 15. Note the Independent Model has an overhead rate similar to the MGMA private practice anesthesiology groups, Section 3, Table 2.

Determining the "profit margin" of our departments may be difficult to accurately assess due to the differences in financial models. In the Budgeted departments, there may be by definition no profit within the department itself. The Independent

	Taxes	Overhead	Group Practice
All Institutions N=65	Mean 7% N = 56	Mean 4% N = 60	Mean 8% N = 61
AMC Classified N= 58	Mean 7% N = 56	Mean 4% N = 54	Mean 9% N = 55
Independent Classified N=7	0% n = 0	Mean 3% N = 6	Mean 7% N = 6

Models may manage their faculty compensation to produce a closer to break even budget, Table 16. The AMC Models have traditional revenue and expenses and for those departments 52.5%

	All Institutions N = 66	AMC Classified N = 59	Independent Classified N = 7
Positive Margin	35/66 = 53 % Mean = \$1,817,299 \$50,481/FTE	31/59 = 52.5 % Mean = \$1,959,323 \$54,426/FTE	4/7 = 57% Mean = \$716,610 \$19,906/FTE
Negative Margin	29/66 = 44% Mean = \$-857,306 \$-23,814/FTE	27/59 = 45.8% Mean = \$-901,954 \$-25,054/FTE	2/7 = 28.6% Mean = \$-254,553 \$-7,071/FTE
Break Even	2/66 = 3 %	1/59 = 1.7%	1/7 = 14.4%

have a positive margin with gift and endowment income excluded in the operating budget, while 43.8% had a negative margin for fiscal year 1999.

Although there are no historical data with which to compare these findings, it is interesting to note that more than half of our AMC departments had an operating profit of approximately \$1.95 million or \$54,000 per FTE, while nearly 46% lost nearly one million dollars or \$25,000 per FTE. Historically departments of anesthesiology have been "the haves" within academic centers and the fact that 46% are significantly in the red is concerning. The Independent Model departments have a similar trend, only to a lesser degree.

CURRENT MANPOWER NEEDS IN ACADEMIC DEPARTMENTS

During the second two weeks in August 2000, a survey was distributed to all SAAC/AAPD members via e-mail asking two, two-part questions regarding their current staffing needs for faculty and CRNA's. They were asked:

1. Are you looking for additional faculty? YES NO
If yes, how many would you like to hire? _____

2. Are you looking for additional CRNA's? YES NO
 If yes, how many would you like to hire? _____

The initial e-mail survey was followed up with two additional requests a week apart. Each of the follow-up requests included the data from the responses to date at the time of each of the requests. The results are presented in Table 17. The overall response rate was 66.2%.

From the 85 departments that are seeking more faculty there were 326 open faculty positions or 3.8 faculty per department (10% shortage). If this rate of faculty recruitment were assumed for the non-responding departments, there would be as many as 494 openings as of August 2000. This suggests a

Table 17: Current Manpower Needs in Academic Departments August 2000		
Response Rate: 66.2% (94/142)	Yes	No
Additional Faculty Needed?	91.5%	8.5%
# of Faculty Needed	326	
Average # Per Department	3.8	
Additional CRNAs Needed?	66.5%	33.5%
# of CRNAs Needed	246	
Average # Per Department	4.0	

significant shortage of faculty currently in our departments, but since there are no previous data regarding faculty needs it is not definitive proof. Historically most academic departments recruit faculty during the winter and spring and have them arrive in during July and August. Consequently, most departments have their highest staffing levels at the end of the summer and generally lose faculty throughout the academic year. It is therefore very concerning that as of August there are such a large number of openings for faculty. The same can be said of CRNAs , Table 17.

Section V - Strategies for Improving Financial Well Being

A. BE PROACTIVE IN MANAGING THE EFFECTS OF THE MEDICARE REIMBURSEMENT AND THE BBA

1. Medicare Reimbursement: Professional Services

Because anesthesiology does not have a PPS direct RBRVS comparable to all other specialties, we remain "outside looking in" on the Medicare PPS program. This makes it very difficult to defend our financial position in group practice contracting. Because anesthesiology "Medicare multiples" must be adjusted upward to achieve similar discount from fee-for-service rates to other specialties, anesthesiology appears to be unfairly and highly compensated. Only an aggressive and unremitting educational program will dispel the belief by other specialists that anesthesiologists are too demanding in their negotiations.

Should academic anesthesiology move to RBRVU based Medicare reimbursement system such as proposed by Jablonski and Marshall.¹⁵ If not, then a set amount for each anesthesiology unit should be used in all group practices internal calculations of fees. Medicare multiples should not be used as they discriminate against anesthesiology. A third possibility is to try to get the practice plan leadership to set all contracts in terms of a percent of the usual and customary or as a fixed discount from standard charge. Ideally physician group practices would use a standard method that has all specialties give a similar discount off of fee-for-service in contract negotiations and capitated contract pay-outs.

2. Calculation Anesthesiology Department Share of DGME

Anesthesiology departments are hospital-based and many receive support from the hospital in a variety of ways. There appear to be few hospitals who actually pay directly to Anesthesiology Departments a payment for teaching residents (which is part of the hospital's DGME payment). The reduced payments that hospitals are experiencing from the BBA do not seem to be directly passed on to Departments of Anesthesiology. The financial crisis that

all teaching hospitals face is likely to force better accounting and Departments of Anesthesiology would be well served in developing high quality accounting of the costs to them of resident teaching borne by the faculty. Tools could be developed by SAAC/APPD to facilitate this accounting. Hospitals then should pay anesthesiology departments for an appropriate percentage of DGME payments. This should be done for all specialties.

3. Hospital Payments of Clinical Providers

Hospitals across the country pay differently for clinical services and with the financial crisis developing it is likely that a more consistent approach should and will be developed as to who pays for residents and CRNAs. Hospitals are reimbursed for hospital and CRNA costs by Medicare. Faculty who are uncompensated for their clinical duties such as those involved in charity care should be compensated some portion of DSH payment. Since the hospitals are compensated by Medicare for residents and CRNAs and paid supplements for services provided to low-income and non-paying patients (DSH), it would be useful for a consistent nation-wide, rationale approach to be adopted. Anesthesiology Departments can make a strong case for hospital funding of all residents (at 1996 level), CRNAs and some "donated" faculty service (coming from uncompensated care, such as staffing a Level 1 trauma center, etc.) It is not permissible for the hospital to pay for resident and faculty research time nor for faculty clinical time already compensated by Medicare as Part B.

4. Determination of House Staff Size

Departments of Anesthesiology must be involved in the decisions regarding house staff size. The hospitals are under a BBA forced mandate to have the same number of residents as of December 1996. There have been enormous fluctuations in the number of anesthesiology residents during the mid and late 1990s.⁶ Discussion with the hospital about the number of total residents and the number of anesthesiology residents needs to occur.

5. Projected Effect of Reduced Hospital Reimbursement by Medicare

Because of the enormous loss in hospital revenues due to the changes in Medicare and Medicaid reimbursement, hospital-based Departments of Anesthesiology can expect less capital equipment, tighter controls on pharmaceutical expenditures, and increased scrutiny on the efficiency of operating rooms. This is an opportunity for anesthesiology to improve these areas by developing more cost-effective practices and by helping the hospital administration and surgery departments design operating room scheduling using productivity measures so that waste is eliminated.

B. KNOWING YOUR DATA

1. Calculate an Anesthesiology Unit Value to Compare Productivity and Compensation.

Productivity for anesthesiologists providing perioperative care is best measured by work-AUs (Anesthesia Units). In most specialties, AUs generated from a patient care encounter have a professional "work" component and a facility or "technical" component, which represents facility and supplies expense. In hospital-based anesthesiology, the technical component is billed separately by the hospital. Therefore, the AUs that we generate from coding our anesthesia records are entirely "work-AUs." Every operating room anesthetic generates a specific number of AUs dictated by a formula involving base-units, time-units, and modifiers. Unfortunately, some of our patient services are not measured in AUs, namely pain management and critical care. For these services, an AU-equivalent can be calculated as follows: divide the total annual professional fee charges for the service by the department AU conversion factor (dollars charged per AU). For example, the University of Arizona Pain Clinic generated \$1.2 million in charges last year, and the anesthesia unit value is \$55/AU. Therefore the AU-equivalent is

$$\text{AU} = \$1,200,000 / \$55 = 21,818 \text{ AU}$$

Table 18 shows various percentiles for anesthesiology AU production per provider per year, along with compensation per AU, both for *all* anesthesiologists⁸ and for *academic* anesthesiologists.⁷

	Mean	25%-ile	Median	75%-ile
AU/year(all)	7,611	4,661	8,748	10,025
Comp/AU(all)	\$42.49	\$25.80	\$30.08	\$46.56
AU/year(acad.)	5,706	2,556	3,593	9,676
Comp/AU(acad)	\$47.37	\$17.83	\$42.37	\$60.33

These numbers can be very

helpful in comparing your department's clinical productivity with that of other departments at your institution and with other anesthesia departments, as we shall see below.

The second row in Table 18 provides an interesting perspective on the average private practice reimbursement per AU. If this truly represents physician compensation per AU, and the average overhead rate is 10%, then the median and mean values of a private practice AU must be:

$$\text{Median AU} = \$30.08/0.9 = \$33.42$$

$$\text{Mean AU} = \$42.49/0.9 = \$47.21$$

These numbers appear high from a Western perspective, but the results of the second row were calculated from only 97 providers. The fact that academic compensation per AU is higher than private practice simply reflects the fact that other (non-clinical) sources of revenue contribute to academic salaries.

How can we use these data to assess our department productivity, compare ourselves with other clinical departments, and determine our appropriate physician salary budget? The following method has been used in negotiating with the Practice Group and the College of Medicine at the University of Arizona.²⁶ Here is how the number of faculty and the salary budget of a department can be calculated.

√ Determine equivalent number of private practice MD's:

The department at the University of Arizona produced 320,000 AU of anesthesia care in FY 99/00. The median productivity of a full-time private practice anesthesiologist is 8,748 AU/year (Table 4). The ratio of these two numbers is then the number of full-time equivalent (FTE) anesthesiologists required to perform our clinical workload in private practice:

$$\begin{aligned} \text{Ideal FTE} &= (\text{Annual AU})/(\text{MGMA median AU}) \\ &= 320,000/8,748 \\ &= 36.6 \text{ FTE} \end{aligned}$$

- √ *Determine the ideal salary budget for this number of FTE in private practice:*

The 1998 MGMA median salary for an anesthesiologist was \$250,200 (Table 1). Multiplying this by the required number of FTE:

$$\begin{aligned} \text{Ideal salary budget} &= \# \text{FTE} \times (\text{MGMA median salary}) \\ &= 36.6 \times \$250,200 \\ &= \$9,157,320. \end{aligned}$$

- √ *Determine the ratio of academic to MGMA private practice salaries in your community; multiply "ideal salary budget" by this ratio.*

This is the most difficult part of the calculation. However, once you have determined this ratio it should be valid for ALL specialists in your academic practice. The Practice Group at the University of Arizona gathered data from salary surveys, deducted our central practice overhead (which is about 25%), and came up with a "local adjustment factor" of 0.56. A better way to calculate this ratio for your practice is to add up all the "ideal salary budgets" for all the clinical departments, and divide that number into the total clinical income that is available to pay salaries. For our example in Arizona:

$$\begin{aligned} \text{Actual salary budget} &= (\text{Ideal salary budget}) \times (\text{adjustment factor}) \\ &= \$9,157,320 \times 0.56 \\ &= \$5,128,099 \end{aligned}$$

This may not be the actual salary budget, but this is what it *should* be, based on a purely objective measure of clinical productivity and market values of salaries. The “adjustment factor” is obviously crucial to the calculation, as it reflects the “cost” of being in academics versus private practice, as well as the local reimbursement market in your community.

The above is an example of how published data from national organizations can help us achieve parity with our fellow departments in terms of salaries, overhead burden, and workload.

2. Knowing Your Minimum Unit Value

Your minimum anesthesia unit reimbursement (MAU) is the actual cost to your department of delivering a unit of anesthesia care. Obviously, you would prefer not to enter contracts that pay you less than this value. If your practice includes Medicare and Medicaid patients, or capitated managed care programs, you probably will have some contracts that are guaranteed to lose money. There is not a department in the country that can show a profit at the current Medicare reimbursement of \$17.83 per unit.

To calculate your MAU, you must first determine the total amount of your department expense budget that supports clinical care. This would include all physician salaries less those supported by research grants, all practice expenses (malpractice insurance, etc.), and all overhead expense not covered by other sources (grants or state support). If some of your research expense must be covered by the clinical service rather than grants, be sure to include this.

Once you have determined your “total clinical expense” budget, simply divide this by the total number of units produced by your department over the same time period. The result is your MAU in dollars per unit. For example, in one year in a typical Western department, the clinical expense budget was \$6.6 million, and 320,000 units were produced. The MAU for this year was $\$6,900,000/320,000 = \21.56 per unit.

Since the MAU is your average cost per unit, it includes contracts that are money losers as well as those that are profitable. Since the money losers are usually contracts regarding which you have no choice or control (Medicare and Medicaid) we should also calculate a "modified" MAU (MMAU) after subtracting these contracts from the payer mix. In order to do this, you must know how much you were paid in these obligatory contracts (whether capitated or not) and how many units you provided on each. Subtract the income from your total clinical expense budget, and subtract the units from your total unit count. Then recalculate the ratio of dollars to units based on what is left. In the example department above, \$1.43 million was collected from Medicare and Medicaid, and 95,667 unit were delivered. The average reimbursement from these two contracts was thus \$14.94 per unit! Now we subtract the \$1.43 million from the original \$6.6 million clinical expense, subtract the 95,667 unit from the original 320,000, and compute the ratio of the remainders to get our MMAU:

$$\text{MMAU} = (\$6.6 \text{ million} - \$1.43 \text{ million}) / (320,000 - 95,667) = \$23.05 \text{ per unit.}$$

This means that even though the overall MAU for this department is \$21.56 per unit (see above), we must negotiate for at least \$23.05 per unit in the contracts we can control in order to break even.

C. INCREASE REVENUE

1. Revenue can be increased by increasing fee for service contract compensation and aggressive negotiation with each payor. The Chair should know the dates of when each contract comes due so that he/she is prepared to negotiate that contract at a unit value that is greater than the minimum required for their viability. Work with the institution to ensure that if the department is forced to accept a contract at a lesser unit, that other support will be provided.

2. Improve hospital support by providing information that services are being provided that are not being reimbursed: clinical services and administrative services. This support may be justified through HCFA reimbursement for IME as outlined in Section 3 of this report and by referring to data from this report, Section 5.

3. Determine capitated minimum per member per month necessary to achieve a break-even value based on a unit recovery analysis. This can be done if there are historical utilization data for a capitated contract. If so, the number of anesthetics provided and anesthesia units of service provided should be calculated and compared to MMAU to provide at least a break even contract. These data can then be used to estimate the per member per month capitation payment to generate that MMAU revenue.

D. RETAIN FACULTY

This may be accomplished by providing incentives other than financial for faculty to consider as they assess their career opportunities; time, research opportunities and support for research, educational opportunities, flexible working environment, supportive working environment. This is the most difficult and at the same time the most important factor in maintaining a viable academic department. If a Chair attempts to maximize faculty salaries by reducing academic time and support, he/she will ultimately end up with a non-academically productive department and most likely will still be unable to compete dollar for dollar with private practice salaries.

CONCLUSION

This report has attempted to clarify the current financial status of our academic training programs as of the fiscal year 1999. To put these data in context, the sections describing manpower, federal reimbursement and published data have also been presented. It is clear there is a significant manpower shortage in anesthesiology which will most likely be felt more severely in academic departments. It is also clear that Medicare's method of reimbursing for anesthesiology places us at financial risk relative to other specialties. Published data suggest that anesthesiologists work longer hours and a greater percentage of those hours in clinical effort than other specialties on average. The departments in academic medical centers pay a greater percentage of their earnings in overhead expenses relative to their community private practice counterparts. These financial pressures have placed nearly 44% of our departments in the red by approximately 6% (expenses in excess of revenue).

As of August 2000 there are approximately 490 open faculty positions (approximately 10% FTE shortage). Given the current increase in class size, there will be an increasing number of graduates over the next three years. In addition the percentage of those graduates who are American medical graduates is also increasing thereby insuring that more of each years graduating class will be available for the US workforce. Nevertheless, the size of this AMG graduating contingent will not surpass 800 until the year 2003 and this is only 54% of the AMG graduates of a decade earlier. For that reason it would appear that there will be a significant faculty shortage for the foreseeable future. Since there are no historical data with respect to open faculty positions or department profitability, it is not possible to make definitive statements regarding the trend of these two essential determinants of departmental viability. It is the author's recommendation that these two parameters be followed on an ongoing basis as part of the annual salary survey. It is also of interest to note that although not all departments employ CRNA's, the shortage of CRNA's in academic departments is nearly as great as the shortage of faculty and on a percentage basis is even greater (15% shortage of CRNA's in those departments that employ CRNA's). It is not clear at this point how the clinical void will be filled. All of these pressures will clearly place increasing stress on the individuals responsible for running training programs. It is hoped that this report will provide background material and current

data that may be of use to those individuals as they work with their institutions to maintain their academic programs while fulfilling their clinical commitments.

REFERENCES

1. Rogers MC, Snyderman R, Rogers EZ: Cultural and organizational implications at academic managed-care networks. *N Engl J Med*, 331:1374-1377, 1994.
2. Anders G: Once a hot specialty, Anesthesiology cools as insurers scale back. *Wall Street Journal*, Friday, March 17, 1995.
3. Grogono AW: Update on Residency Composition 1960 - 1999. *American Society of Anesthesiologists News Letter*, 63:17-19, 1999.
4. Federal Register: Implementing BBA Provision. *Federal Register* 412.105, Direct Graduate Medical Education 413.86, May 12, 1998.
5. Association of American Medical Colleges Fact Sheet. *Association of American Medical Colleges*, Vol 3(5), 1999.
6. Reves JG, Greene NM: Anesthesiology and the Academic Medical Center: Place and Promise at the Start of the New Millennium. Chp 3 The Present (1990-2000), *Inter Anesth Clinics*, Vol 38(2)45-96, 2000.
7. Academic Practice Faculty Compensation and Production Survey. *Medical Group Management Association*, Englewood, CO, 80112, pg 14, 2000.
8. Physician Compensation and Production Survey. *Medical Group Management Association*, Englewood, CO, 80112, pg 28, 1999.
9. Estimation of Physician Work Force Requirements in Anesthesiology. *ABT Report for the ASA*, September 16, 1994.
10. Dr. Thomas Cromwell, Secretary of the ASA, Personal Communication.
11. Dr. Frank Hughes, American Board of Anesthesiology, Personal Communication.
12. Pokras R, Kozak LJ, McCarthy E: Ambulatory and inpatient procedures in United States, 1994. *Vital & Health Statistics - Series 13: Data from the National Health Survey* . (132):1-113, 1997.
13. Kozak LJ, Owings MF: Ambulatory and inpatient procedures in United States, 1994. *Vital & Health Statistics - Series 13: Data from the National Health Survey* . (135):1-116, 1998.
14. Owings MF, Kozak LJ: Ambulatory and inpatient procedures in United States, 1994. *Vital & Health Statistics - Series 13: Data from the National Health Survey* . (139):1-119, 1998.
15. Jablonski VN, Marshall WK: A methodology for the calculation of anesthesia relative value units. *ASA Newsletter*, April 2000.

16. Cohen NA: Between the RUC and a hard place. ASA Newsletter, June 2000.
17. Scott M: Medicare payments to decline based on anesthesia practice expenses. ASA Newsletter, October 1999.
18. Scott M: Society requests work value re-evaluation in connection with MFS five-year review. ASA Newsletter April 2000.
19. Lubarsky DA, Reves JG: Using Medicare multiples results in disproportionate reimbursement for anesthesiologists compared to other physicians. J Clin Anesth 12:238-41, 2000.
20. Association of American Medical Colleges: Issue Briefs I- Medicare disproportionate share (DSH) payments.
21. Association of American Medical Colleges: Issue Briefs – Medicare fiscal year 2000 hospital inpatient prospective payment system: final rule.
22. American Hospital Association Legislative Advisory: Balanced budget act relief legislation. November 1999.
23. Association of American Medical Colleges: Issue Briefs – America's teaching hospitals still hurt from the BBA.
24. Association of American Medical Colleges. Fact Sheet. Volume 3(5), 1999, Association of American Medical Colleges.
25. Society of Academic Anesthesiology Chairs: "1999 SAAC Salary Survey." Gainesville FL, October 1999.
26. Steven J. Barker, PhD, MD, Chair, Department of Anesthesiology, University of Arizona, Personal Communication.

PERSONNEL

House Staff	Dept Pays	Hospital Pays	Med School Pays	Other Pays
Interns # _____	= # _____	+ # _____	+ # _____	+ # _____
CA 1-3 # _____	= # _____	+ # _____	+ # _____	+ # _____
Fellows ACGME # _____ (Peds, Pain, CCM)	= # _____	+ # _____	+ # _____	+ # _____

House Staff (Salary) Expense Deficit to Department. \$ _____

	Dept Pays	Hospital Pays	Med School Pays	Other Pays
Non-ACGME Fellows # _____	= # _____	+ # _____	+ # _____	+ # _____
Research Fellows # _____	= # _____	+ # _____	+ # _____	+ # _____
CRNAs or AAs # _____	= # _____	+ # _____	+ # _____	+ # _____

MD FACULTY ACTIVITY: Average over the Department (The Department is defined as those faculty working at the primary teaching hospital)

% of time spent clinically.	_____
% of time spent teaching.	_____
% of time spent in research and/or grant management.	_____
% of time spent in administration.	_____
	100%

B U D G E T

Are You Funded by an Annual Budgeting Process by a County or a Group Practice in Such a Way that the Following Financial Data are Difficult to Determine? YES _____ NO _____
 If yes, fill out only what you can.

Do You Receive Hospital/Medical School Support for:

OR Management	Yes _____	No _____	Amount Received	\$ _____
OB	Yes _____	No _____	Amount Received	\$ _____
ICU	Yes _____	No _____	Amount Received	\$ _____
Pre Op	Yes _____	No _____	Amount Received	\$ _____
General Administrative (Include GME funds)	Yes _____	No _____	Amount Received	\$ _____
Other	Yes _____	No _____	Amount Received	\$ _____
TOTAL HOSPITAL SUPPORT RECEIVED.				\$ _____

R E I M B U R S E M E N T

Payor Mix	<u>% of Payor Mix</u>	<u>Collection Rate as % of Full Charges</u>
Medicare	_____	Medicare _____
Medicaid	_____	Medicaid _____
HMO/Managed Care	_____	HMO/Managed Care _____
Indemnity Insurance	_____	Indemnity Insurance _____
Self Pay	_____	Self Pay _____
Other	_____	Other _____
TOTAL =	100%	Overall Collection Rate _____%
Full Amount of Charge	\$ _____ per unit	

REVENUE

REVENUE:	<u>\$(Dollars)</u>		<u>%(Percent)</u>
Clinical Care	_____		_____
Research	_____		_____
Teaching	_____		_____
Administration	_____		_____
Endowment/investment	_____		_____
Other	_____		_____
TOTAL	\$ _____	=	_____ 100%

REVENUE BY SOURCE	<u>\$(Dollars)</u>		<u>%(Percent)</u>
Practice of Anesthesia (Clinical Care)			
• Physician Fees	_____		_____
• CRNA	_____		_____
• VA Contract	_____		_____
• Other	_____		_____
 Research			
• Federal Funding	_____		_____
• Industrial Research	_____		_____
• Other Research	_____		_____
 Other Support (Teaching & Administrative)			
• Medical School Support	_____		_____
• State Support	_____		_____
• Hospital	_____		_____
• Other	_____		_____
• Non-operating Income (Endowments, Investments, Gifts)	_____		_____
TOTAL	\$ _____	=	_____ 100%

EXPENSES

EXPENSES	<u>\$ (Dollars)</u>	<u>% (Percent of Revenue)</u>
TAXES		
• Dean	_____	_____
• President	_____	_____
• Other	_____	_____
OVERHEAD (rent, etc)		
• Hospital	_____	_____
• Med School	_____	_____
• Malpractice	_____	_____
PROFESSIONAL GROUP PRACTICE		
• Clinic overhead	_____	_____
• Other Practice Overhead	_____	_____
• Billing & collections including compliance	_____	_____
COMPENSATION		
• Faculty (including bonuses)	_____	_____
• House Staff	_____	_____
• Fellows	_____	_____
• CRNA	_____	_____
• Other Personnel	_____	_____
Research (\$ from operating fund)	_____	_____
Other (travel, supplies, etc)	_____	_____
TOTAL OPERATING EXPENSES	_____	_____

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A Demographic, Service, and Financial Survey of Anesthesia Training Programs in the United States

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In February 2000, a demographic, service, and finance survey was sent to the directors of anesthesiology training programs in the United States under the auspices of the Society of Academic Anesthesia Chairs/Association of Academic Program Directors. In August of 2000, 2001, and 2002, shorter follow-up surveys were sent to the same program directors requesting the numbers of vacancies in faculty positions and certified registered nurse anesthetists (CRNA) positions. The August 2001 survey also inquired if departments had positive or negative financial margins for the fiscal year ending June 2001. The August 2002 survey included the questions of the 2001 survey and additionally asked if the departments had had an increase or decrease in institutional support and the amount of that current support. The survey results revealed that the average program had 36 anesthetizing locations and 36 faculty. Those faculty spent 69% of their time providing clinical service. Approximately one-half of the departments paid for some of their residents, whereas the other 50% paid for none. Eighty-five percent of the departments employed CRNAs who were funded by the hospital in one third of the departments. In 2000, departments received \$34,319/yr in support per faculty full-time equivalent (FTE) from their institutions and had a mean revenue of \$407,000/yr/faculty FTE. In 2002, the department's institutional support per FTE increased to \$59,680 (a 74% increase since 2000). The departments in academic medical

centers paid 20% in overhead expenses, whereas departments in nonacademic medical centers paid 10%. In 2000, 2001, and 2002, the percentage of departments with positive margins was 53%, 53%, and 65%, respectively, whereas the departments with a negative margin decreased from 44% in the year 2000 to 38% in 2001 and 33% in 2002. For the departments with a positive margin, the amount of margin per FTE over this 3-yr period was approximately \$50,000, \$15,000, and \$30,000, respectively. Although the percentage of departments with a negative margin has been decreasing, the negative margin per FTE seems to be increasing from approximately \$24,000 to \$43,000. The number of departments with open faculty positions has decreased from 91.5% in the year 2000 to 83.5% in 2001 and 78.4% in 2002; in these departments, the number of open faculty positions has also decreased from 3.8 in 2000 to 3.9 in 2001 to 3.4 in 2002. The number of open CRNA positions seems to have been relatively constant with approximately two thirds of the departments requiring an average of approximately four CRNAs each. Overall, academic anesthesiology departments fiscal security seems to have eroded with an increased dependence on institutional support. Departments pay larger overhead rates relative to private practice, and there seems to be a continued, but possibly decreasing, shortage of faculty.

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Over the past decade, a variety of stressors have been placed on American academic medical centers and academic anesthesiology programs in particular. Professional fee reimbursement has progressively declined specifically for those specialties

involved with procedures (1). Academic medical centers' income has not only been reduced because of the emergence of health maintenance organizations, but in the later part of the 1990s, the Balanced Budget Act significantly reduced direct and indirect graduate medical education payments (2). The mid-1990s saw a dramatic decrease in residents matching into anesthesiology (3). This reduction in resident numbers has subsequently produced a workforce shortage facing the specialty in the United States (U.S.) that may last for the next 5-10 yr (4-6). The current shortage of anesthesiologists has made it difficult for academic

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medical centers to recruit and retain adequate numbers of faculty (7). Many specialties at academic medical centers face problems of decreased reimbursement for their professional fees, but departments of anesthesiology are also met with the additional threat of being unable to compete financially for faculty because of the improving quality and quantity of job offers in private practice. Medicare's disproportionately poor reimbursements for anesthesia care and the large cost of overhead have been two other factors that have placed academic anesthesia departments in financial jeopardy (8,9). Because of the adverse consequences these pressures may have on U.S. training programs, the Society of Academic Anesthesiology Chairs/Association of Anesthesiology Program Directors (SAAC/AAPD)¹ council commissioned a white paper to be written to provide background information regarding these threats to the specialty. This paper "Surviving the Perfect Storm: the Financial Environment of Academic Medical Centers" was presented at this society's meeting in October 2000 (10,11). The intent of this report was not only to provide a framework by which academic chairs could plan for the future, but also to have information regarding the issues facing the specialty available to medical school deans and hospital administrators. To generate the data required for this report, two surveys were sent to the program directors of the U.S. training programs between February and August of 2000. As a follow-up to this report, two more surveys were sent in August of 2001 and 2002. The purpose of this current paper is to present the results of these four surveys and discuss their implications with respect to the future financial stability of the U.S. training programs in anesthesiology.

Methods

Four surveys were sent to the program directors of the anesthesiology training programs in the U.S. in February 2000 and in August 2000, 2001, and 2002. The purpose of these surveys was to assess the current financial and workforce status of the training programs in the U.S. The February 2000 survey requested information regarding departmental demographics with respect to personnel, budgeted support, reimbursement, revenue, and expenses (Appendix I: SAAC/AAPD Financial Survey). In August 2000, a

brief survey was conducted of the same group of programs, requesting their current workforce needs with respect to faculty and certified registered nurse anesthetists (CRNAs). In August 2001, a third survey was conducted asking the same workforce questions and also requesting the departments' financial margins for the fiscal year ending June 30, 2001 (Appendix II: SAAC/AAPD Financial Survey). The fourth survey was conducted in August 2002 asking the same questions as the 2001 survey and included questions regarding institutional support (Appendix II). The purpose of these follow-up surveys was to determine if there were trends with respect to workforce needs or financial conditions that were not captured in the first survey. The February 2000 survey was sent by mail with reminders sent by email, fax, and telephone. The follow-up surveys in August 2000, 2001, and 2002 were sent by e-mail with e-mail reminders. All surveys were sent to the current program directors listed in the SAAC/AAPD directory.

The SAAC are the program directors in anesthesia departments within medical schools. The AAPD direct the training programs in the U.S. Therefore, the SAAC members are a large subset of the AAPD. The AAPD members who are not members of SAAC are the program directors in institutions that do not have medical schools. Organizationally, these distinctions became moot over 20 yr ago when both groups merged to form the SAAC/AAPD, but the distinction becomes relevant when analyzing the financial data because of the differences in taxation and institutional support. For the purposes of this paper, we will refer to the non-SAAC members as AAPD. Another distinction can be made with respect to departments that are budgeted as an expense in larger institutions and therefore may not have detailed revenue and expense information. Because of these differences in financial structure, some portions of the financial survey were analyzed by dividing departments into three categories. The first category consists of those departments in academic medical centers with medical schools; they are financially responsible for their revenue and expenses; those departments in general receive support funds from the medical school and hospital and in turn pay taxes and group practice overhead expenses; this group will be referred to as the academic medical center model (AMC Model). The second group consists of departments that are more fully integrated into hospitals or group practices in which they are budgeted within the overall finances of the institution; for these departments it was not possible to complete much of the financial portion of the survey; this second group will be referred to as the budgeted department model (Budgeted Model). The third group includes the departments that are almost completely independent with respect to their finances and more analogous to private practice departments; they

¹ The Society of Academic Anesthesiology Chairs/Associate of Anesthesia Program Directors is a joint organization of the training program directors in Anesthesiology in the United States. The SAAC members are those program directors (department chairs) in institutions with medical schools, whereas the AAPD is the organization for all anesthesia program directors whether they are at an institution with or without a medical school. There are 142 SAAC/AAPD members.

pay little or no taxes and in turn receive little or no support from the hospitals; we will refer to this third group as the independent department model (Independent Model). In the following report, we will present overall data and group specific data, where appropriate, for each of these models.

Results

The survey in Appendix I was distributed by mail to 142 program directors (113 SAAC institutions) with follow-up reminders sent by e-mail, fax, and telephone. An 80% response rate was achieved from the SAAC members (90 of 113) and a 34% response rate from AAPD members (10 of 29). Two AAPD departments reported that they no longer had residencies and therefore were excluded from this survey analysis. Seventeen surveys were returned with insufficient data to be included in the analysis, leaving a final usable response rate for SAAC member departments of 66% and 21% for AAPD departments, with an overall response rate of 56%. The response rates for the August 2000, 2001, and 2002 follow-up surveys were 66.2%, 72.5%, and 63.8%, respectively.

The overall demographic data are presented in Table 1. On average, the programs have 36 anesthetizing locations (23% of which are non-operating room [OR] locations) and 36 clinical faculty full-time equivalents (FTE). The departments average 30 residents in the 3 clinical anesthesia years, which is a 1:1.2 faculty-to-resident ratio. They conducted an average of 19,929 cases per year or 554 per faculty member. Sixty-nine percent of these departments direct preoperative clinics, and these departments see approximately 37% of all surgical patients in those clinics. The anesthesiology departments also manage chronic pain clinics and acute pain services (Table 1). Forty-one percent of the institutions manage the anesthesia service at Veteran's Administration Hospitals and 38% of those do so at a financial deficit to the department that averages \$326,644/yr or \$9,129/FTE (Table 2).

Faculty spends approximately 69% of their time clinically, 16% in teaching assignments, 8% in research, and 7% in administration (Table 3). Table 4 presents the expenses for the trainees' salaries. In no departments surveyed were all of the residents' salaries paid with departmental funds. In 50.6%, the departments paid for no residents, whereas in the remaining 49.4%, the departments paid for some residents. Table 5 presents the findings of the non-Accreditation Council for Graduate Medical Education (ACGME) approved fellows (cardiac anesthesia, neuro anesthesia, obstetrical anesthesia, and research). Fifty-seven percent of programs have an average of 4.4 non-ACGME fellows. Fifty-four percent of non-ACGME approved fellows (research and clinical) are paid for completely by the departments, whereas

Table 1. Demographics (all institutions)

	Mean ± sd
No. ORs n = 80	28.3 ± 17.8
No. other anesthesiology locations n = 76	7.9 ± 8.0
No. of cases with anesthesia per yr n = 79	19,929 ± 12,330
No. OB deliveries w/anesthesia per yr n = 72	2842 ± 3006
No. pain clinic visits per yr n = 74	4308 ± 3277
No. preop clinic visits per yr n = 55	7431 ± 5382
No. clinical FTEs n = 80	36 ± 21.5
No. of full time research FTEs n = 62	3.5 ± 3.0
No. of residents n = 80	30.1 ± 21

ORs = operating rooms; OB = obstetric; Preop = preoperative; FTE = full time equivalent.

**Table 2. Veterans Association (VA) Hospital Staffing
n = 68**

VA staffing responsibility	yes = 41%	no = 59%
If yes, financial deficit?	yes = 38%	no = 62%
If financial deficit, how much?	mean	\$326,644
	mean/FTE	\$9129

FTE = full time equivalent.

Table 3. MD Faculty Activity, Percent Time (all institutions)

	Mean ± sd
Clinically n = 80	69% ± 17
Teaching n = 80	16% ± 12
Research n = 79	8% ± 7
Administration n = 78	7% ± 4

Note: Not all departments responded in all categories.

21.7% of departments pay for some, and 23.9% pay for none.

Eighty-five percent of the programs employ CRNAs, 44.1% of which are paid for totally by the department (averaging 14.6 CRNAs per department), whereas 33.8% are paid totally by the hospital (averaging 23.6 CRNAs per department) (Table 6a). Of the departments that split the CRNA funding between the hospital and anesthesiology departments, the average split is 47% hospital and 53% department (Table 6b).

Institutional (hospital-medical school) support for clinical, administrative, and teaching activities are presented in Tables 7a-c for both the 2000 survey and the

Table 4. Accreditation Council for Graduate Medical Education Approved Resident Salary Funding

	Department <i>n</i> = 79 total	Hospital <i>n</i> = 79 total	Medical school <i>n</i> = 79 total	Other <i>n</i> = 79 total
Pay for all	0% <i>n</i> = 0	44.3% <i>n</i> = 35	2.5% <i>n</i> = 2	1.3% <i>n</i> = 1
Pay partially	49.4% <i>n</i> = 39	49.4% <i>n</i> = 39	8.9% <i>n</i> = 7	19% <i>n</i> = 15
Pay for none	50.6% <i>n</i> = 40	6.3% <i>n</i> = 5	88.6% <i>n</i> = 70	79.7% <i>n</i> = 63

Table 5. Non-Accreditation Council for Graduate Medical Education (ACGME) Approved Fellows Funding (all institutions)

	Department pays <i>n</i> = 46	Hospital pays <i>n</i> = 46
Pay for all	25/46 = 54.3% <i>n</i> = 25	7/46 = 13.2% <i>n</i> = 7
Pay for partially	10/46 = 21.7% <i>n</i> = 10	4/46 = 8.7% <i>n</i> = 4
Pay for none	11/46 = 23.9% <i>n</i> = 11	35/46 = 76.1% <i>n</i> = 35

Note: Thirty-four of 80 institutions do not have a non-ACGME approved fellowship program. Forty-six of 80 institutions have an average of 4.4 non-ACGME approved fellows.
n = 80.

Table 6a. Certified Registered Nurse Anesthetist (CRNA)/Anesthesia Assistant (AA) Funding

		No. of CRNAs
Yes: CRNAs/AAs	85%	68
No: CRNAs/AAs	15%	12
100% funded by the department	30/68 = 44.1%	14.6
100% funded by the hospital	23/68 = 33.8%	23.6
Percent partially funded	15/68 = 22.1%	

n = 80.

Table 6b.

Partially funded breakdown	Percent	No. of CRNAs
Funded by department	53	17.2
Funded by hospital	47	21.7

CRNA = certified registered nurse anesthetist; AA = anesthesia assistant.

2002 follow-up survey. Some institutions receive an overall support budget that is not itemized; therefore, the funds allocated to each area of potential support is the average number of dollars for which those itemized data were provided. Overall, departments received an average of \$1,235,474/yr, which represents \$34,319/faculty in 2000 (Table 7c). The AMC Model receives substantially more support than the Independent Model (\$34,987/FTE versus \$17,034/FTE) (Table

7a). Although by the year 2002 40% of the departments had an increase in support and 24% had a decrease, the average of overall support increased by 89% to \$2,329,748 or \$59,906/FTE (Tables 7, b and c).

Table 8 presents payor mix and collection rates. In 2000, on average, departments charged \$62.00 per unit and had an average collection rate of 42.5% or a net collections of \$26.35 per unit. The average unit charge increased to \$65.90 in 2001.

Table 9 and Table 10a present itemized revenue and expense data by percent of total dollars for the AMC and Independent Models. The financial data for the Budgeted Model department are incomplete and therefore not presented in this analysis. The revenue per FTE in the AMC Model is similar to that of the Independent Model, \$403,611 and \$411,067, respectively. The combination of taxes to deans, university presidents, overheads (e.g., rent), and group practice overheads (including billing and malpractice) totaled 20% for the AMC Model and 10% for the Independent Model (Table 10b).

In 2000, approximately half of the AMC departments had an operating profit averaging \$1.95 million or \$54,426/FTE, whereas nearly 46% lost approximately \$900,000 or \$25,000/FTE (Table 11). The Independent Model departments had a similar trend, only to a lesser degree. Table 12 presents the margin analysis over the last 3 yr. The percentage of departments with a positive margin remained relatively constant at 53% until 2002 when they increased to 65%. The overall margin and margin per FTE decreased from 2000 to 2001 but then increased in 2002, which coincided with an increase in institutional support of (overall average) \$1,094,274 (Table 7c). During the same time period, the number of departments with a negative margin has progressively decreased, but the amount of the negative margin has increased from approximately \$850,000 (or \$24,000/FTE) in the years 2000 and 2001 to over \$1.5 million (or \$40,000/FTE) in 2002 (Table 12).

In 2000, of the 85 (91.5%) departments that were seeking more faculty, there were 326 open faculty positions or 3.8 faculty per department (10% shortage). The percent of departments needing faculty has progressively decreased over the past 3 yr to 78%; these departments are now seeking an average of 3.4 faculty per department (Table 13). Departments had similar needs for CRNAs (Table 13).

Discussion

Although there are some financial data regarding academic practices available from the Medical Group Management Association (MGMA) and data regarding residency positions from the Residency Review Committee and the American Board of Anesthesiology, this paper presents the first data describing the

Table 7a. Hospital/Medical School/State Support

	Operating room	Obstetric	Intensive care unit	Preoperative	General administration	Other ^a	Total institutional support	
							2000 total support	2000 support per full-time equivalent
All institutions <i>n</i> = 66	65% 225,073	18% 194,046	36% 212,226	30% 107,899	61% 431,841	61% 798,394	100% 1,235,474	\$34,319
AMC classified <i>n</i> = 59	70% 225,849	20% 194,046	41% 212,266	32% 111,735	61% 455,919	61% 863,500	100% 1,329,510	\$34,987
Independent classified <i>n</i> = 7	29% 201,150	0% 0	0% 0	14% 35,000	57% 215,138	57% 212,442	100% \$442,884	\$17,034

AMC = academic medical center.
^a Numbers represent institutions that reported itemized breakdowns.

Table 7b. Percentage Change in Institutional Support from Fiscal Year 2000 to 2002

Increased	40%	(<i>n</i> = 34)
Decreased	24%	(<i>n</i> = 10)
Unchanged	36%	(<i>n</i> = 31)

Table 7c. Average Institutional Support from Fiscal Year 2000 to 2002

	2000	2002	Dollar increase	Percent increase
Total support	\$1,235,474	\$2,329,748	1,094,274	89
Support/FTE	\$ 34,319	\$ 59,906	25,587	75 ^a

^a Percent increase per full time equivalent (FTE) is not the same as percent of dollar increase because of the different number of faculty in departments over the 2-yr period.

Table 8. Reimbursement Payor Mix (all institutions)

Payor	Mean (%)
Medicare	8.5
Medicaid	8.6
HMO	22.6
Insurance	27.4
Self pay	12.5
Other	20
Overall collection rate	42.5
Full amount of charge per unit 2000	\$62.60
Full amount of charge per unit 2001	\$65.90

n = 80.

U.S. anesthesiology training programs from a demographic, service, and financial point of view. The impetus for this survey was the culmination of adverse financial and workforce issues facing the U.S. anesthesiology training programs as a result of the changes in the 1990s, including professional fees, hospital reimbursement, and the decrease in size of residency classes (1,3,7). The primary survey (2000) provided a snapshot in time of the U.S. anesthesiology training

programs, and the follow-up surveys provided information regarding the trends in finances and workforce. It is interesting to note that the average department has a number of faculty approximately equaling the number of anesthetizing locations, and 22% of those locations are non-ORs. That means that each anesthetizing location needs to generate sufficient revenue to support a faculty FTE with administrative overhead and some academic time. Given that offsite locations generally provide less revenue and that surgical times are usually longer at teaching institutions, it may be a challenge to meet these revenue expectations. Survey results demonstrate that the revenue per FTE was approximately \$407,000, 8% of which (\$34,000) was from institutional support payments in the year 2000; in this year, 44% of the departments had negative margins, whereas 53% had healthy positive margins. Within a year, the positive margin had been reduced by nearly 70%. During the same time period, the workforce survey demonstrated an approximate 10% open faculty positions. This was also the same time when the number of graduating residents was at a low point, and job opportunities were prevalent throughout the country (4,7). It would seem that between the years 2000 and 2002 many program directors requested additional support from their institutions to retain and recruit faculty during this workforce shortage. This is demonstrated by a nearly doubling of institutional support reaching almost \$60,000 per faculty in the year 2002. It also seems that this increased revenue to the departments was used to increase faculty salaries to facilitate recruitment and retain faculty. Table 14 contains the salary data from the SAAC Salary Survey of the years 2000 and 2002 (Rebecca Lovely, University of Florida, personal communication, 2002). These data demonstrate a substantial increase in salary, especially at the lower levels. Instructor salaries have increased 40%, and assistant, associate, and professor salaries have increased 14%,

Table 9. Revenues

	Clinical care	Research	Teaching and administration	Endowment and investments	Other	Mean total revenue per institution	Revenue per FTE ± SD
All institutions n = 66	Mean 79% n = 66	Mean 6% n = 57	Mean 10% n = 61	Mean 2% n = 47	Mean 7% n = 46	Mean n = 66 \$14,952,350	\$407,420
AMC classified n = 59	Mean 78% n = 59	Mean 6% n = 54	Mean 10% n = 56	Mean 2% n = 45	Mean 7% n = 40	Mean n = 59 \$15,458,319	\$403,611
Independent classified n = 7	Mean 91% n = 7	Mean 1% n = 3	Mean 4% n = 5	Mean 3% n = 2	Mean 6% n = 6	Mean n = 7 \$10,687,754	\$411,067

AMC = academic medical center; FTE = full time equivalent.

Table 10a. Expenses

	Total overhead	Compensation	Research	Other
All institutions n = 65	Mean 19% n = 65	Mean 69% n = 65	Mean 4% n = 48	Mean 6% n = 58
AMC classified n = 58	Mean 20% n = 58	Mean 68% n = 58	Mean 4% n = 45	Mean 6% n = 52
Independent classified n = 7	Mean 10% n = 7	Mean 80% n = 7	Mean 3% n = 3	Mean 6% n = 6

AMC = academic medical center.

Table 10b. Itemized Overhead

	Taxes	Overhead	Group practice
All institutions n = 65	Mean 7% n = 56	Mean 4% n = 60	Mean 8% n = 61
AMC classified n = 58	Mean 7% n = 56	Mean 4% n = 54	Mean 9% n = 55
Independent classified n = 7	0% n = 0	Mean 3% n = 6	Mean 7% n = 6

AMC = academic medical center.

10%, and 1%, respectively. If the average department of 36 FTE is assumed to have a distribution of faculty at ranks as presented in the SAAC survey, then the overall cost of these salary increases would be approximately \$923,000. If one assumes a 20% benefit rate, it would require approximately \$1,100,000 for a department to provide these salary increases. Coincidentally, from 2000 to 2002, the increase in average departmental support from the institutions was approximately \$1,100,000 (Table 7c). Starting salaries in academic departments have increased dramatically, most likely to be more competitive with private practice. It seems this strategy has worked because the number of faculty openings in the training departments has decreased; this would either imply that the departments are able to compete effectively with private practice or that the overall job market is saturating nationwide. Recent data would not suggest the latter (6).

Academic faculty do not expect to have the same salary as private practitioners, but they do expect academic support and academic time. This may not be the salary expectation of all specialties. Interestingly, Figure 1 demonstrates that academic salaries for anesthesiologists at all levels are smaller relative to private practice salaries compared with other procedural and nonprocedural disciplines. Note that even at the full professor rank, academic anesthesiologist salaries never reach those of private practice, whereas general internal medicine, general surgery, and pediatrics professor salaries exceed those of private practice salaries. Even in heavily procedure-oriented specialties, such as orthopedic surgery, academic salaries reach nearly 90% of the private practice salary when orthopedists attain the rank of professor, whereas anesthesiologists reach only 83% of their private practice counterparts (12-14). This explains why it may be more difficult to recruit academic anesthesiologists at the assistant professor level and even more difficult to retain anesthesiologists when they see that their future compensation will always lag behind private practice salaries. The other major academic specialties that face similar compensation difficulties are radiology, pathology, cardiology, and hematology/oncology (12-14).

Although the overall response rate for this study is only 56%, it compares favorably with the 25%-31% response rate for MGMA reports (12-14). This is surprising given the length and complexity of the current survey compared with the data presented from the MGMA reports. This relatively large response rate

Table 11. Margin Analysis for the Year 2000

	All institutions n = 66	AMC classified n = 59	Independent classified n = 7
Positive margin	35 of 66 = 53% Mean = \$1,817,299 \$50,481/FTE	31 of 59 = 52.5% Mean = \$1,959,323 \$54,426/FTE	4 of 7 = 57% Mean = \$716,610 \$19,906/FTE
Negative margin	29 of 66 = 44% Mean = \$-857,306 \$-23,814/FTE	27 of 59 = 45.8% Mean = \$-901,954 \$-25,054/FTE	2 of 7 = 28.6% Mean = \$-254,554 \$-7,071/FTE
Break even	2 of 66 = 3%	1 of 59 = 1.7%	1 of 7 = 14.4%

AMC = academic medical center; FTE = full time equivalent.

Table 12. Margin Analysis Fiscal Years 2000, 2001, and 2002

Department margin	2000	2001	2002
Positive margin	53% \$1,817,299 \$50,481/FTE	53% \$577,666 \$15,202	65% \$1,102,719 \$28,354/FTE
Negative margin	44% \$847,306 \$23,814/FTE	38% \$840,400 \$21,491	33% \$1,572,021 \$40,423/FTE
Response rate	66.2%	72.5%	63.8%

FTE = full time equivalent.

Table 13. Current Workforce Needs in Academic Departments August 2000/2001/2002

	2000	2001	2002
Response rate	66.2%	72.5%	63.8%
Departments needing additional faculty	91.5%	83.5%	78.4%
Average no. per department	3.8	3.9	3.4
Departments needing additional certified registered nurse anesthetists	66.5%	75%	67.1%
Average no. per department	4.0	4.4	3.6

Table 14. Society of Academic Anesthesia Chair (SAAC) Salary Data* For Academic Years Starting 2000 and 2002

	2000	2002	Dollar increase	Percent increase
Instructor	\$144,250	\$201,528	\$57,278	39.7
Assistant professor	\$183,000	\$209,000	\$26,000	14.2
Associate professor	\$210,000	\$231,496	\$21,000	10.0
Professor	\$239,182	\$242,156	\$ 2971	1.1

* Data for national average for stipends only. SAAC Salary Survey, Rebecca Lovely, Department of Anesthesiology, University of Florida, P.O. Box 100254, Gainesville, FL 32610.

was most likely because of two reasons. First, the initial mailings of these surveys were followed up multiple times by letter, e-mail, and contact by phone to encourage responses. Second, the respondents had an interest in receiving the data from the survey because it relates directly to their jobs, and the respondents were informed that the results of the survey

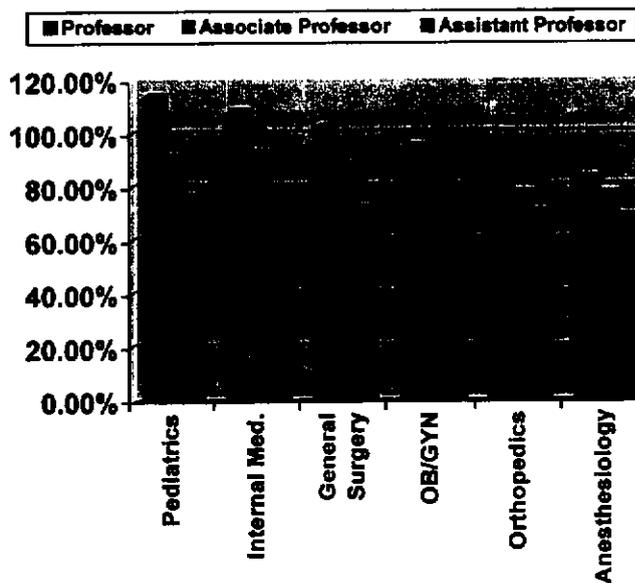


Figure 1. This histogram graphs academic salaries at three levels (assistant, associate, and full professor) for six specialties as a percentage of private practice income. These data are from the Medical Group Management Association (MGMA) (12,13).

would be distributed at the Fall 2000 meeting of the SAAC/AAPD. Despite this encouraging response rate, the data may be flawed by having a selection bias with respect to the respondents and nonrespondents, thereby not having the results reflect the average department. One way of attempting to assess accuracy of the results is to compare the findings with those of another survey that includes the same question. For example, the average number of clinical faculty from this survey was 36 FTEs, which compares favorably with the number of faculty reported by the SAAC Salary Survey for the year 2000 of 38.7 FTEs (Rebecca Lovely, University of Florida, personal communication, 2002). This salary survey is distributed to the SAAC departments by the Department of Anesthesiology at the University of Florida, Gainesville, each year, and the results are sent to all SAAC departments. In the year 2000, this salary survey was sent to the 113 program directors of the SAAC departments and had

88 respondents (78% response rate) (Rebecca Lovely, University of Florida, personal communication, 2002). If the data from the SAAC members within this current report are analyzed, one finds that there are 38.3 faculty, which is nearly identical to the SAAC salary survey number of 38.7. In addition, the MGMA academic survey for 2002 (based on 2001 data) found that the average department had 42 faculty. This MGMA report had a response rate of only 26.3%; therefore, although the number of faculty is close to that found in this current report, with the small response rate, it would not be expected to be the same (12). Also, this current report found that the average number of residents in anesthesiology programs was 30.2. The American Board of Anesthesiology reported an average of 29.3 residents for the 134 programs they had approved during the 2000 academic year. The close agreement of resident and faculty numbers suggests that current survey data represent national results (4).

A second concern with any survey is the accuracy of the responses. This accuracy is not because of the respondents knowingly providing inaccurate data but more to the respondents not interpreting the question as intended. For example, clinical FTEs in Table 1 may have been interpreted as anesthesiologist faculty time assigned clinically as opposed to the number of employed FTE faculty anesthesiologists. Hopefully, respondents answered this correctly, especially given the questions that appear on page 2 of this survey, which requests information regarding the percent of time that MD faculty spend in clinical service versus teaching, research, or administration. Nevertheless, it is possible that many of the questions were interpreted differently by respondents, thereby potentially affecting the accuracy of the results.

Finally, it should be stated that the results are presented as mean values, thereby reflecting the average department but not necessarily reflecting the large variation between departments. This became very clear when analyzing the financial data, which required analysis of the departments in the three categories: AMC Model, Budgeted Model, and Independent Model. Most of the data in the financial section are from the AMC Model departments, so these results would probably most closely reflect the true situation of these departments on average.

In summary, although the number of applicants to U.S. training programs and resident class size have increased over the past two years, the workforce shortage in the U.S. seems to be here for at least the next half decade (4-6). During the next few years, it will be crucially important that academic anesthesiology departments remain solvent and be able to recruit and retain qualified faculty to train the increasing number of residents. Academic departments pay larger overhead expenses not only to support their academic missions but the academic missions of their institutions and their group practices, as well (9). For many specialties within an academic medical center, the group practice experience rates are less than the expenses in the private environment (1,9). This averaging of practice expenses places academic anesthesia departments at a disadvantage relative to other specialties within their institutions (9). Because the anesthesia faculty in this survey spent approximately 70% of their time providing clinical service, there is little time left for the other aspects of academic life. If this time is further reduced to support more clinical income, their jobs will seem to be little different than that of a private practitioner. As anesthesiology departments face deficit budgets, they are also faced with the difficult problem of retaining faculty to provide the breadth of educational opportunity and services requested by their institutions. If these departments functioned as corporations, they would consider eliminating money-losing ventures, which in the case of anesthesiology departments might be off-site anesthesia locations, pain clinics, preoperative clinics, and services in labor and delivery. An alternative approach of asking for increased institutional support seems to have been effective in nearly half of the departments surveyed in this study. Overall, the anesthesiology training programs have received a significant increase in support that coincides with a substantial increase in faculty salaries, especially at the instructor and assistant professor levels. It is hoped that this support will continue to allow departments to recruit and retain qualified faculty and to provide them with sufficient time to develop academic careers. The viability of the specialty of anesthesiology depends upon these individuals to train the next generation of practitioners and to be the source of discovery of new knowledge.

PERSONNEL

House Staff		Dept Pays		Hospital Pays		Med School Pays		Other Pays
Interns # _____	=	# _____	+	# _____	+	# _____	+	# _____
CA 1-3 # _____	=	# _____	+	# _____	+	# _____	+	# _____
Fellows ACGME # _____ (Peds, Pain, CCM)	=	# _____	+	# _____	+	# _____	+	# _____

House Staff (Salary) Expense Deficit to Department. \$ _____

		Dept Pays		Hospital Pays		Med School Pays		Other Pays
Non-ACGME Fellows # _____	=	# _____	+	# _____	+	# _____	+	# _____
Research Fellows # _____	=	# _____	+	# _____	+	# _____	+	# _____
CRNAs or AAs # _____	=	# _____	+	# _____	+	# _____	+	# _____

MD FACULTY ACTIVITY: Average over the Department (The Department is defined as those faculty working at the primary teaching hospital)

- % of time spent clinically. _____
- % of time spent teaching. _____
- % of time spent in research and/or grant management. _____
- % of time spent in administration. _____

100%

BUDGET

Are You Funded by an Annual Budgeting Process by a County or a Group Practice in Such a Way that the Following Financial Data are Difficult to Determine? YES _____ NO _____
 If yes, fill out only what you can.

Do You Receive Hospital/Medical School Support for:

OR Management	Yes _____	No _____	Amount Received \$ _____
OB	Yes _____	No _____	Amount Received \$ _____
ICU	Yes _____	No _____	Amount Received \$ _____
Pre Op	Yes _____	No _____	Amount Received \$ _____
General Administrative (Include GME funds)	Yes _____	No _____	Amount Received \$ _____
Other	Yes _____	No _____	Amount Received \$ _____
TOTAL HOSPITAL SUPPORT RECEIVED.....			\$ _____

REIMBURSEMENT

Payor Mix	<u>% of Payor Mix</u>		<u>Collection Rate as % of Full Charges</u>
Medicare	_____	Medicare	_____
Medicaid	_____	Medicaid	_____
HMO/Managed Care	_____	HMO/Managed Care	_____
Indemnity Insurance	_____	Indemnity Insurance	_____
Self Pay	_____	Self Pay	_____
Other	_____	Other	_____
TOTAL =	100%	Overall Collection Rate	_____ %
Full Amount of Charge \$ _____ per unit			

REVENUE

REVENUE:	<u>\$ (Dollars)</u>	<u>% (Percent)</u>
Clinical Care	_____	_____
Research	_____	_____
Teaching	_____	_____
Administration	_____	_____
Endowment/investment	_____	_____
Other	_____	_____
TOTAL	\$ _____	_____

=

100%

REVENUE BY SOURCE	<u>\$ (Dollars)</u>	<u>% (Percent)</u>
--------------------------	---------------------	--------------------

Practice of Anesthesia (Clinical Care)

- Physician Fees _____
- CRNA _____
- VA Contract _____
- Other _____

Research

- Federal Funding _____
- Industrial Research _____
- Other Research _____

Other Support (Teaching & Administrative)

- Medical School Support _____
- State Support _____
- Hospital _____
- Other _____
- Non-operating Income
(Endowments, Investments, Gifts) _____

TOTAL	\$ _____	=	_____
--------------	-----------------	----------	--------------

100%

EXPENSES

EXPENSES	<u>\$ (Dollars)</u>	<u>% (Percent of Revenue)</u>
TAXES		
• Dean	_____	_____
• President	_____	_____
• Other	_____	_____
OVERHEAD (rent, etc)		
• Hospital	_____	_____
• Med School	_____	_____
• Malpractice	_____	_____
PROFESSIONAL GROUP PRACTICE		
• Clinic overhead	_____	_____
• Other Practice Overhead	_____	_____
• Billing & collections including compliance	_____	_____
COMPENSATION		
• Faculty (including bonuses)	_____	_____
• House Staff	_____	_____
• Fellows	_____	_____
• CRNA	_____	_____
• Other Personnel	_____	_____
Research (\$ from operating fund)	_____	_____
Other (travel, supplies, etc)	_____	_____
TOTAL OPERATING EXPENSES	_____	_____

Appendix II: 2000, 2001 and 2002 Follow-Up SAAC/AAPD Surveys

This is another BRIEF follow-up survey to the Perfect Storm Report.

Please reply by following the directions below:

1. Select "Reply" to this e-mail message.
2. Scroll down and answer the questions by clicking in between the parenthesis.
3. Send/Return this email to me.

I. Staffing

Do you have open faculty positions? Yes () No ()
If yes, how many? ()
How many full-time equivalent MD faculty do you have total? ()

Do you have CRNAs? Yes () No ()
If yes, what percentage does the department fund? ()%
What is the department's cost? (\$)

Do you have open CRNA positions? Yes () No ()
If yes, how many? ()

II. Department Finance (for fiscal year ending 6/30/02)*

Did your department have a positive margin? Yes () No ()
(not including gifts or investments)
If yes, approximately how much? (\$), ()% of budget

Did your department have a negative margin? Yes () No ()
(not including gifts or investments)
If yes, approximately how much? (\$), ()% of budget

III. Departmental Financial Support from Hospital, Medical School or other sources.†

How many faculty anesthesiologists do you have (FTE)? (_____)

Has your department had a change in institutional financial support (all sources: hospital, medical school, state, other) since fiscal year ending June 2000?
(_____increase)
(check one) (_____decrease)
(_____stayed the same)

If you have had an increase, what is the approx. amount of total support?(\$_____)
what is this as an approx.% of your budget? (_____%)

* These questions were added to the 2001 survey

† These questions were added to the 2002 survey

References

1. Reves JG, Greene NM. Anesthesiology and the Academic Medical Center: place and promise at the start of the new millennium. *Int Anesthesiol Clin* 2000;38:45-96.
2. Federal Register: Implementing BBA Provision. *Federal Register* 412.105, Direct Graduate Medical Education 413.86. May 12th, 1998.
3. Grogono AW. Update on residency composition 1960-1999. *ASA Newsl* 1999;63:17-9.
4. Grogono AW. Residency composition and numbers graduating from residencies and CRNA schools. *ASA Newsl* 2001;65:19-23.
5. Schubert A, Eckhout G, Cooperider T, Kuhel A. Evidence of a current and lasting national anesthesia personnel shortfall: scope and implications. *Mayo Clin Proc* 2001;76:995-1010.
6. Eckhout G, Schubert A, Tremper K. An updated forecast of the National Anesthesia Personnel Shortfall. *Anesthesiology* 2002;96:A1100.
7. Tremper KK, Gelman S. Surviving the perfect storm: challenges faced by our training programs. *ASA Newsl* February, 2001.
8. Lubarsky DA, Reves JG. Using medicare multiples results in disproportionate reimbursement for anesthesiologists compared to other physicians. *J Clin Anesth* 2000;12:238-41.
9. Barker SJ. Lord or vassal? Academic anesthesiology finances in 2000. *Anesth Analg* 2001;93:294-300.
10. Tremper KK, Barker SJ, Gelman S, et al. Surviving the perfect storm: the financial environment of academic anesthesia. Society of Academic Anesthesiology Chairs/Association of Anesthesiology Program Directors Web Site: <http://www.asahq.org/aapd-saac/text.reports.ssi>. Report from ASA Annual Meeting October, 2000.
11. Tremper KK, Reves JG, Barker SJ, et al. Financial environment of academic anesthesia. *Advances in anesthesia*. Carlsbad, CA: Mosby, Inc, 2001:1-35.
12. Academic Practice Faculty Compensation and Production Survey. Englewood, CO, Medical Group Management Association, 2000:14.
13. Physician Compensation and Production Survey. 2001 Report Based on 2000 Data. Englewood, CO, Medical Group Management Association, 2000:28-9, Table 1.
14. 2000-2001 AAMC Report of Medical School Faculty Salaries. Summary statistics on medical school faculty compensation for all schools MD degree, clinical science departments, pp 24-36.

Faculty and Finances of United States Anesthesiology Training Programs: 2002–2003

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Between February, 2000 and August, 2002 three surveys have been submitted to the program directors of the anesthesiology training programs in the United States (U.S.) to assess the departments' needs for faculty and financial support from their institutions. In this article we present the results of a fourth follow-up survey. This survey also asked questions regarding the need for additional support to meet the new 80-h workweek resident requirement and asked the average academic time offered to faculty. The average department has 40 faculty members with 3.7 open faculty positions in the 78% of departments with open positions. Only 25% of the departments planned to add personnel to comply with the 80-h resident workweek. Fifty-one percent of the departments had

a positive financial margin of \$15,908/full-time equivalent (FTE) faculty anesthesiologist (faculty FTE), whereas 34% had a negative margin of \$42,603/faculty FTE. The overall institutional support was \$85,607/faculty FTE, which is a 43% increase over the previous year. The average academic time provided to faculty was 13.8%, a decline from 20% in 2000. Twenty-five percent of departments have closed an anesthetizing location as a result of a lack of faculty in 2003. Open faculty positions in U.S. training programs have remained fairly constant at 8% to 10% from 2000 to 2003. Institutional support for training departments has more than doubled since 2000, reaching approximately \$85,000/faculty in 2003. (Anesth Analg 2004;99:1185–92)

The past decade has seen dramatic swings in the number of medical students entering anesthesiology training programs in the United States (U.S.) (1). Because of a real or perceived excess of anesthesiologists in this country, there was a substantial decline in resident class size in the mid-1990s. The graduating class size decreased from 1796 in 1995 to 934 in 2000 (1,2). This reduction in practitioners entering the U.S. anesthesiology workforce has resulted in a nationwide shortage that may last more than 5 years (2–4). The decrease in supply of anesthesiologists has caused a significant increase in demand and salaries in both private practice and in teaching departments (2003 Society of Academic Anesthesiology Chairs Salary Survey, personal communication with Rebecca Lovely, University of Florida, Gainesville, 2003) (5,6). The resulting competitive salary environment has

acutely affected the finances of academic training departments (2). As faculty salaries have increased, academic departments' finances have been compromised, placing in jeopardy their ability to train more residents and to conduct an academic program (2,7). In the year 2000, a committee of the Society of Academic Anesthesiology Chairs and Association of Anesthesiology Program Directors (SAAC/AAPD) produced a white paper that reviewed the financial and workforce problems facing anesthesiology training programs in the U.S. (2,7,8). A portion of this white paper included a comprehensive survey of the U.S. training departments to determine the current status of faculty and finances in the year 2000. Follow-up surveys were conducted in 2001 and 2002 to determine the trends with respect to workforce needs and financial status (2,3). The purpose of this current article is to report the results of the most recent follow-up survey and to compare these data with that of the 3 previous years.

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Methods

For the past 4 years, e-mail surveys have been sent to the program directors of the U.S. anesthesiology training programs (2). The follow-up surveys conducted in

Table 1. Anesthesiology Departments' Clinical Workforce

Response rate 65%	Mean \pm SD	Median	Minimum	Maximum
Faculty	40.3 \pm 23.0	34.3	11	107
Residents	39.4 \pm 19.8	36	12	90
CRNAs	25.9 \pm 37.4	15	1	205

10% of residents are funded by departments. 90% of departments have certified registered nurse anesthetists (CRNAs). 58% of CRNAs are funded by the departments.

2001, 2002, and 2003 have focused on workforce needs: open faculty positions and open Certified Registered Nurse Anesthetist (CRNA) positions, departmental financial margins, and the amount of institutional support received. This current survey, distributed in August of 2003, also included questions regarding support for resident salaries and questions relating to anesthesia practitioners that were added as a result of the recently implemented Accreditation Council of Graduate Medical Education (ACGME) resident 80-h workweek (9). Additionally, program directors were asked the percentage of nonclinical time provided to faculty. (APPENDIX I) The email survey was sent in August; email reminders were sent every 2 weeks for the next 8 weeks to those who did not respond. In October of 2003, an additional email survey was distributed that asked if the departments had closed anesthetizing locations as a result of a lack of faculty or CRNAs and what was their anesthesia unit charge. (APPENDIX II) This survey was redistributed by email to all program directors and then weekly for the next 2 weeks to the nonresponders.

Results

The survey in Appendix I was distributed by email to 135 SAAC/AAPD program directors. An overall response rate of 65% ($n = 88$) was achieved. The results are presented in Tables 1-5. The average department has 40 faculty and 39 residents. For the 90% ($n = 78$) who have CRNAs, departments employ an average of 26. Seventy-eight percent of departments have an average of 3.7 open faculty positions whereas 21% ($n = 18$) of departments have no open positions. Overall, departments provided faculty with 13.8% non-clinical time where 1 day per week is considered 20%. For the departments who have CRNAs, 64% ($n = 56$) have an average of 3.9 open positions (Table 2).

Twenty-five percent of the departments anticipate recruiting new personnel to comply with the ACGME mandates for resident work hours. These departments have or will be adding residents, CRNAs, or faculty to fulfill these requirements (Table 3). Departments, on average, pay for four of their 39 residents and 58% ($n = 51$) of their CRNAs.

From a financial funds flow model, U.S. training departments can be divided into three types: "Academic

Medical Center Model" (AMC Model) programs are those with departments within medical schools, "Budgeted Department Model" (Budgeted Model) are those in which departments are part of a larger clinical enterprise which manages the finances, and the "Independent Department Model" (Independent Model) wherein departments are structured like a private practice group (2). Because of the funding mechanism for Budgeted Model departments, they are unable to provide the financial data requested in these surveys and are therefore not included in the financial portion of the results (2).

For the fiscal year ending June 30, 2003, of the 78 program directors who responded to this question, 58% ($n = 45$) of departments had a positive financial margin whereas 38% ($n = 30$) had a negative financial margin, with 4% breaking even. For those departments with a positive margin, the mean margin was \$636,338 or \$15,908 per faculty full-time equivalent (FTE) (Table 4, Fig. 1a). Those departments with a negative margin had an average loss of \$1,704,139 or \$42,603 per faculty FTE (Table 4, Fig. 1a). When these data are compared with the last 3 years, they demonstrate that the percent of departments with positive and negative margins are similar, but that the positive margins are decreasing and the negative margins are increasing (Table 4, Fig. 1a).

The average institutional support totaled \$3,424,296 or \$85,607 per faculty FTE (Table 5, Fig. 1b). Fifty-nine percent of this support was received from the hospital whereas 18% and 23% were received from the medical school or other sources, respectively. When these data are compared with the previous survey results it appears that total institutional support per FTE has increased by 75% between the years 2000 and 2002 and then by another 43% in 2003.

The second survey in 2003 noted that 25% of departments had closed anesthetizing locations as a result of a lack of faculty and 14% had done so as a result of a lack of CRNAs. The average anesthesia unit charge was \$74.80 ($n = 75$) (Table 5).

Discussion

During the late 1980s and early 1990s, anesthesiology in the U.S. was a very popular choice for U.S. medical students and the training programs progressively increased the size of their classes (7). The

Table 2. Open Faculty and Certified Registered Nurse Anesthetist Positions

	2000	2001	2002	2003
Open faculty positions (No.)	3.8	3.9	3.4	3.7
Departments w/ open positions (%)	91.5	83.5	78.4	78.4
Open CRNA positions (No.)	4.0	4.4	3.6	3.9
Departments with open positions (%)	66.5	75.0	67.18	63.6

2000-2002 data are from Tremper et al. (2) *Anesth Analg* 2003;96:1432-6. The response rate for 2003 was 65%. 90% of departments have certified registered nurse anesthetists (CRNAs).

Table 3. Additional Personnel Needed to Comply with 80 H Resident Workweek

	Percentage (Number) of departments adding	Number added	Number needed
Residents	28% (25)	0.2 ± 0.6	2.3 ± 3.0
CRNAs	28% (25)	0.7 ± 1.0	3.2 ± 5.1
Faculty	25% (22)	1.5 ± 1.9	2.5 ± 2.9

CRNAs = certified registered nurse anesthetists.
25% of departments added (will add) residents; 75% do not need to add personnel.

Table 4. Department Margin Analysis Fiscal Years 2000-2003

Department Margin	2000	2001	2002	2003
Positive margin	53%	53%	65%	58%
	\$1,817,299	\$577,666	\$1,102,719	\$636,338
	\$50,481/FTE	\$15,202/FTE	\$28,354/FTE	\$15,908/FTE
Negative margin	44%	38%	33%	38%
	\$847,306	\$840,400	\$1,572,021	\$1,704,139
	\$23,814/FTE	\$21,491/FTE	\$40,423/FTE	\$42,603/FTE
Response rate	66.2%	72.5%	63.8%	65%

FTE = full-time equivalent.
25% of departments added (will add) residents; 75% do not need to add personnel.

Table 5. Average Institutional Support and Anesthesia Unit Value

Year	2000	2002	2003
Total support	\$1,235,474	\$2,329,748	\$3,424,296*
Support/FTE	\$ 34,319	\$ 59,906	\$ 85,607*
Support/FTE median	\$ 19,444	\$ 30,223	\$ 58,750
Support/FTE maximum	\$ 161,073	\$ 514,271	\$ 380,354
Support/FTE minimum	\$ 833	\$ 5,143	\$ 3,000
Anesthesia unit value charge	\$ 62.60	n/a	\$ 74.80†

FTE = full-time equivalent.
* Response rate 65%; † response rate 61%.

American Society of Anesthesiologists became concerned that the numbers of graduating residents would be larger than the national need and consequently commissioned a manpower analysis to be done by Abt Associates, Inc (10). This analysis reported in 1994 that although there may have been a considerable oversupply of anesthesiologists, this prediction depended upon a variety of assumptions, including growth rate of surgical procedures and the degree to which anesthesia was provided in the care team mode with supervision of CRNAs (10).

Also in the mid-1990s, recommendations were being made that U.S. medical schools should be producing 50% specialists and 50% primary care providers. This recommendation was based on the expected need for primary care gatekeepers for the managed care and capitated programs of the future. In addition, a reduction in specialists would be appropriate given the anticipated reduction in subspecialty care and surgical procedures. On March 17, 1995, an article appeared in the *Wall Street Journal* that received significant attention in the medical school

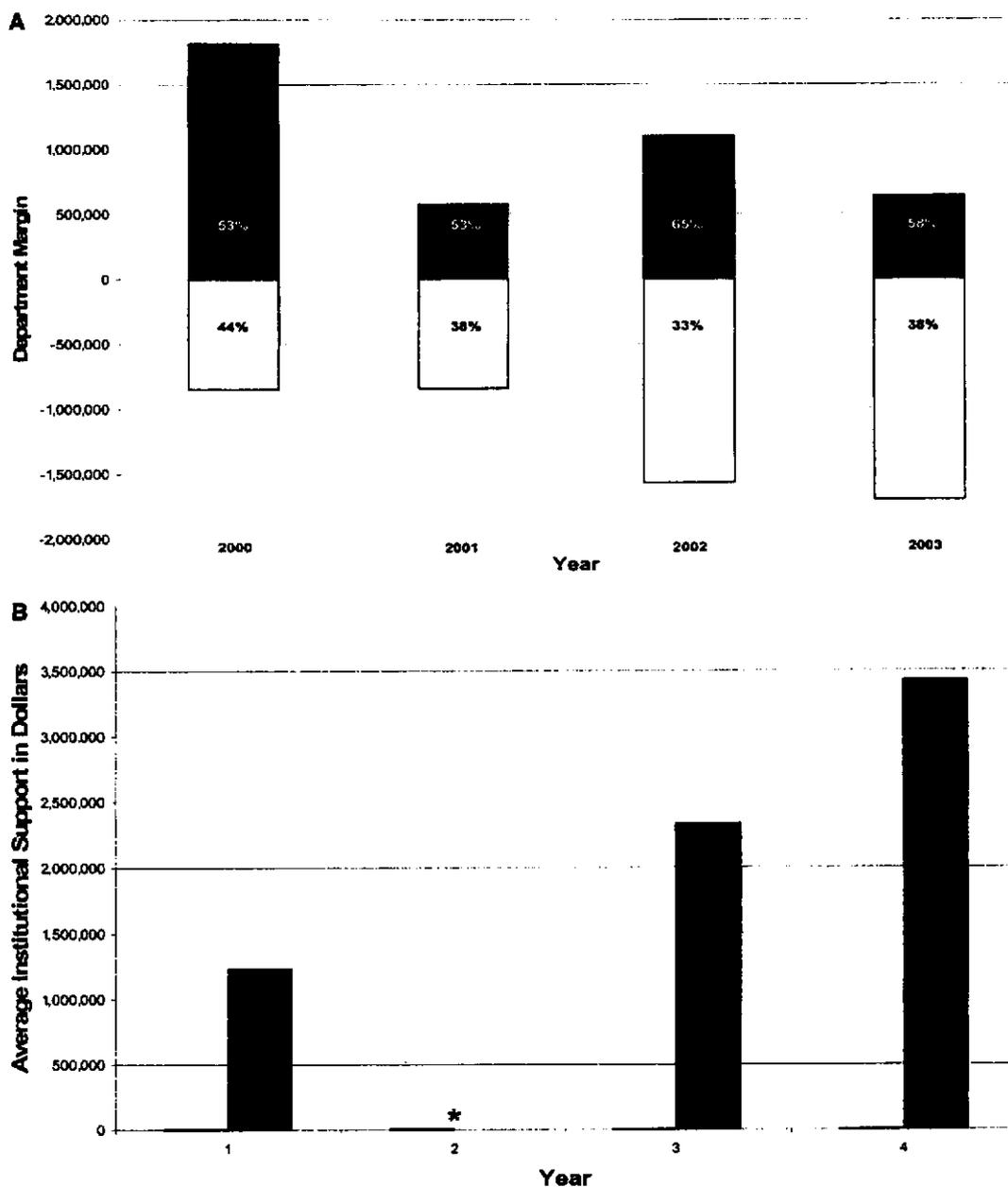


Figure 1. a. This figure illustrates the trends in financial margins of the departments (not including the Budgeted Model departments) over the 4 yr, 2000–2003. The margins are normalized to the number of faculty in each department. The percentage reported within the bars are the percentage of the departments with positive and negative margins respectively (1). b. These are the average department’s institutional support dollars for the years 2000, 2002, and 2003. *These data were not surveyed in 2001.

community. This article recounted the difficulties that a recent anesthesiology graduate had in finding employment (11). All of these forces directed medical students away from selecting a career in anesthesiology. The result was a dramatic decrease in the number of U.S. medical graduates entering into the match for anesthesiology in 1996.

It now appears that there is a substantial shortage of anesthesiologists that may persist for the next 5 to 10

years (3,4). Future needs in the U.S. anesthesia workforce have been proven to be very difficult to predict (3). United States workforce needs depend not only on estimated surgical caseload and practitioner retirement rate (which in turn may be dependent on the state of the economy) but also on the average work hours per practitioner and the percentage of anesthesiologists who will be working out of the operating room (OR), e.g., pain and critical care (3).

It is well documented that the salaries of faculty anesthesiologists who work in training programs are less than those of their private practice counterparts (2003 SAAC salary survey, personal communication with Rebecca Lovely, University of Florida, Gainesville, 2003) (5,6). Anesthesiologists who choose academic careers have the opportunity to teach and participate in academic pursuits and consequently have an expectation to have academic time to participate in these nonclinical activities. When the number of faculty in a training department decreases, the department chair must either limit academic time or reduce coverage for the OR. Because most hospitals rely heavily on OR revenue, it is extremely difficult for an anesthesiology department to close ORs for the purposes of maintaining academic time for its faculty. From the results of this survey it appears that departments have both closed anesthetizing locations and reduced academic time. The survey demonstrates that 25% of departments have closed an anesthetizing location as a result of a lack of faculty.

In the 2000 survey, the average academic time was 20%, which has been reduced to 13.8% in 2003. As academic time is reduced, the job of a faculty in a training department becomes more similar to that of a private practitioner except for a smaller salary. For this reason, faculty may ultimately be recruited to better paying positions in private practice unless academic time is provided or salaries are maintained at a more competitive level. As the number of faculty openings in academic departments has been relatively constant over the past 4 years and the institutional support and academic salaries have increased significantly, it is clear that the training hospitals have realized the difficulty in recruiting and retaining the faculty without augmenting salaries (Table 5; 2003 SAAC salary survey, personal communication with Rebecca Lovely, University of Florida, Gainesville, 2003). This does not address the problem of insufficient faculty and inadequate academic time, but it appears to have stabilized the faculty shortage in the academic departments.

It has also been noted that in recent years the percent of articles submitted to *Anesthesiology* and *Anesthesia & Analgesia* from U.S. departments has decreased compared with international departments (personal communications with Ronald Miller, MD, editor, *Anesthesia & Analgesia* and Michael Todd, MD, editor, *Anesthesiology*). Although this decrease in submission rate to the two primary U.S. anesthesiology journals does not in itself prove that academic productivity in U.S. departments is decreasing, it is a concerning trend. Additionally, should the number of anesthesiologists increase relative to demand, the hospitals would most likely reduce the current level of support, causing an acute decrease in salaries. Because over the short term increasing salaries cannot increase the number of anesthesiologists but only add to the workforce by reducing the number of retirees

and increasing the number of hours worked per practitioner, the supply and demand effect on salaries may continue.

Survey data, in general, may misrepresent reality because of a small response rate, a skewed response population, or errors in the respondents' understanding of the survey questions. The 65% response rate of this current survey compares favorably with the 25%–31% response rate of the Medical Group Management Association reports (5,6). In addition, because this is the fourth consecutive year of surveying the same population regarding a similar topic, it is likely that these data are at least consistent and potentially improved over the previous 3 years. The large response rate achieved in this survey is likely attributable to the fact that the respondent program directors were informed that they would receive the results of this survey at their national meeting and these results may be useful to them in managing their departments. This survey also compares well with the results of the most recent SAAC Salary Survey, which noted the average department had 39.5 faculty, whereas this current survey noted 40.3 faculty (personal communication with Rebecca Lovely, University of Florida, Gainesville, 2003). This same SAAC survey noted 266 funded faculty vacancy positions in the 86 responding departments. The current survey notes 69 of the 88 responding departments had an average of 3.7 faculty openings or 255 open faculty positions. This excellent agreement between these two surveys provides some evidence of accuracy or at least consistency.

It is possible that, although the response rate has been relatively consistent, the demographics of the respondents over time could have shifted and thus influenced the year-to-year comparison of mean values. Figure 2 presents the number of responding departments by faculty size over the 4-year period. There is no statistically significant change in distribution of responding departments by faculty size. Figure 3 presents the number of respondents by department funding category, i.e., AMC, Budgeted, and Independent Models. Although there were a significantly decreased number of Budgeted Model respondents after the year 2000, none of these departments are included in the financial analysis because of a lack of financial data for that group (2). The Independent Model and AMC Model responding departments have remained relatively constant over the 4 years (Fig. 3).

The institutional support per faculty FTE presented in Table 5 demonstrates a large variation between departments. One explanation for this wide range may be the expenses of CRNA salaries. The CRNAs may be employed by the hospital in some institutions and the expenses will not be part of the department expenses. In other departments the CRNA expenses are part of the department budget and these salary expenses may require significant support from the hospital. The 2000 survey found that 44% ($n = 30$) of the departments fully

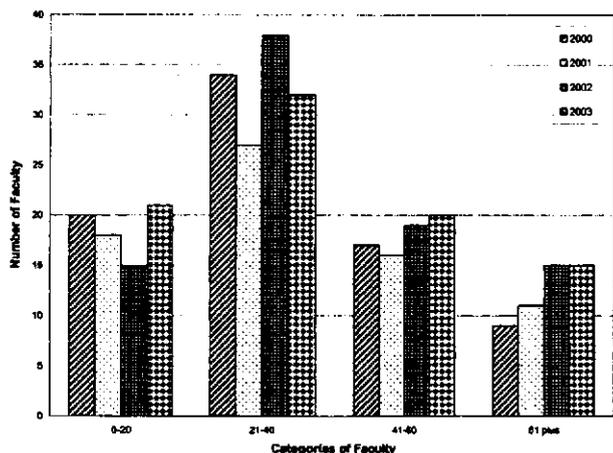


Figure 2. This figure illustrates the number of responding departments in 4 groups by faculty size (0–20, 21–40, 41–60, more than 60) over 4 yr. χ^2 analysis revealed no differences in the distribution of responding programs between the 2000 and 2003 surveys.

funded their CRNA salaries with 22% ($n = 15$) only partially funded their CRNA salaries. Thirty-four percent ($n = 23$) of CRNAs were completely funded by the hospital. The details of CRNA support dollars were beyond the scope of the three follow-up surveys, so the reason for the wide variation in hospital support cannot be definitively linked to CRNA costs.

We conclude that the current shortage of anesthesiologists in the U.S. has resulted in significant salary increases for faculty in the U.S. training programs and

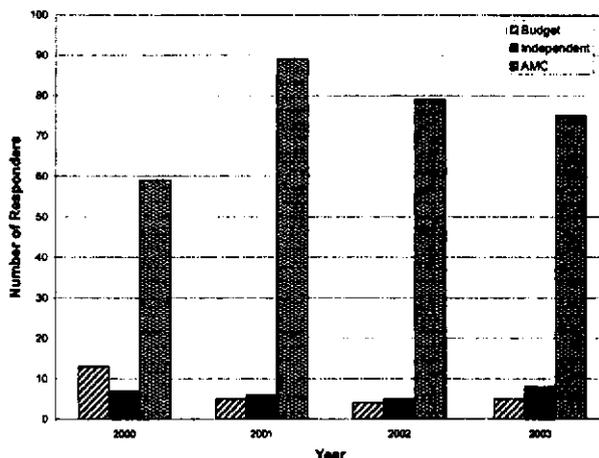


Figure 3. This figure illustrates the number of responding departments by department funding category (Academic Medical Center Model [AMC], Budgeted Model, and Independent Model). Although there appears to be a decrease in responding departments in the Budgeted Model, these departments did not contribute financial data.

thus, departments have become increasingly dependent on institutional support to provide those salaries. Despite this increased funding, the financial condition of the U.S. departments is deteriorating, academic time is decreasing, and 25% of departments have closed an anesthetizing location because of a lack of faculty. These trends may gradually reverse as the size of the graduating residency class increases over the next 5 years.

Appendix 1.

2003 Follow-Up SAAC/AAPD Survey

This is a follow-up survey to the Perfect Storm Report.

Please reply by following the directions below:

1. Select "Reply" to this e-mail message.
2. Scroll down and answer the questions by clicking in between the parenthesis.
3. Send/Return this email to me.

I. Staffing

How many employed FTE faculty anesthesiologists do you have? __

Do you have open faculty positions? Yes () No ()

If yes, how many? ()

Do you have CRNAs? Yes () No ()

If yes, how many CRNAs do you have in total? __

If yes, how many does the department pay for? __

Do you have open CRNA positions? Yes () No ()

If yes, how many? ()

II. Residents and the 80 hour workweek

How many residents are in your program? __

How many residents are paid by the department? __

Do you anticipate having to hire/recruit additional personnel because of the new Residency Review Committee (RRC) mandated resident work rules?

Yes () No ()

If yes, if adding residents is an option for you, how many additional residents have you added? __ How many still needed? __

If yes, how many additional CRNAs have you added? __ How many still needed? __

If yes, how many additional faculty anesthesiologists have you added? __

How many still needed? __

III. Department Finance (for fiscal year ending 6/30/03)

Did your department have a positive margin? Yes () No ()

(not including gifts or investments)

How much \$__ Percentage of total budget__%

Did your department have a negative margin? Yes () No ()

(not including gifts or investments)

How much \$__ Percentage of total budget__%

IV. Departmental Financial Support from Hospital, Medical School or other sources.

What is your annual support for your department from all sources (hospital, medical school, state, etc)

How much from the Hospital? \$__ Percent of total budget__%

How much from the Med School? \$__ Percent of total budget__%

How much from Other sources? \$__ Percent of total budget__%

V. Faculty Academic Time.

What is the average amount of non-clinical (academic) time per faculty, not counting the day after in-hospital call? (one day per week = 20%).__%

Appendix 2.

Mini-survey in follow-up to August 2003 survey

Thank you for completing the 2003 Follow-Up SAAC/AAPD Survey. Below are three additional questions that we would like to add to the results. It would be greatly appreciated if you would take a few moments to complete the questions.

Please reply by following the directions below:

1. Select "Reply" to this e-mail message.
2. Scroll down and answer the questions by clicking in between the parenthesis.
3. Send/Return this email to me.

What is your unit value charge for anesthesia? \$__ per unit

Have you reduced or closed any anesthetizing locations (OR or offsite) due to lack of faculty?

Yes () No ()

Have you reduced or closed any anesthetizing locations (OR or offsite) due to lack of CRNAs?

Yes () No ()

Thank you for taking the time to complete this e-mail.

Sincerely,

Kevin K. Tremper, PhD, MD
Robert B. Sweet Professor and Chair
Department of Anesthesiology
University of Michigan

References

1. Grogono AW. National resident matching program results for 2003: continuing strong recruitment, few surprises. *ASA Newsletter* 2003;67:5.
2. Tremper KK, Barker SJ, Gelman S, et al. A demographic, service, and financial survey of anesthesia training programs in the United States. *Anesth Analg* 2003;96:1432-46.
3. Schubert A, Eckhout G, Tremper KK. An updated view of the national anesthesia personnel shortfall. *Anesth Analg* 2003;96:207-14.
4. Schubert A, Eckhout G, Cooperider T, Kuhel A. Evidence of a current and lasting national anesthesia personnel shortfall: scope and implications. *Mayo Clin Proc* 2001;76:995-1010.
5. Medical Group Management Association academic practice compensation and production survey for faculty and management: 2003 report based on 2002 data. Englewood, CO: MGMA Center for Research, 2003.
6. Medical Group Management Association physician compensation and production survey: 2003 based on 2002 data. Englewood, CO: MGMA Center for Research, 2003.
7. Tremper KK, Reves JG, Barker SJ, et al. The financial environment of academic anesthesia. In: Lake CL, Johnson JO, eds. *Advances in Anesthesia*. Carlsbad, CA: Mosby, Inc. 2001:1-35.
8. Tremper KK, Barker SJ, Gelman S, et al. Surviving the perfect storm: the financial environment of academic anesthesia, October 2000. White Paper Commissioned by Society of Academic Anesthesiology Chairs and the Association of Anesthesiology Program Directors (SAAC/AAPD). Available at: <http://www.asahq.org/aapd-saac/homepage.html>.
9. Accreditation Council for Graduate Medical Education, resident duty hour documents. Available at: <http://www.ACGME.org>.
10. Estimation of physician workforce requirements in anesthesiology. Bethesda, MD: Abt Associates, Inc., 1994.
11. Anders G. Once a hot specialty, anesthesiology cools as insurers scale back. *Wall Street Journal*. March 17, 1995.

Abstract:

The decrease in resident applicants for United States anesthesiology training programs in the mid 1990s has resulted in a national anesthesiologist shortage. This shortage has been associated with increased salaries for anesthesiologists in academic institutions. Salary increases have placed the financial condition of academic training departments in jeopardy, requiring increasing support from their institutions. In the year 2000, a nationwide survey of the financial status of the U.S. anesthesiology training programs was conducted. Follow-up surveys have been conducted each year thereafter. We present the results of the fifth such survey. One-hundred-twenty-eight departments were surveyed, with a response rate of 73%. The average department employs 45 faculty and 81% of those departments have an average of 3.3 open positions. Of the 91% of departments who employ Certified Registered Nurse Anesthetists (CRNAs) (an average of 25 CRNAs/dept), 73% have an average of 4.2 open CRNA positions. The average department received \$3,787,835 (or \$97,621/faculty) in institutional support, which is an increase over the 2003 amount of \$85,607/faculty. In 36.6% of the departments a portion of these support dollars (\$1,888,111) was provided to support CRNA salaries. Therefore, the support to departments for faculty averaged \$81,696/faculty, after the CRNA dollars were removed. Faculty academic time averaged 16% (where 20% is one day/week) and departments billed an average of 11,954 anesthesia units/faculty/year. These results demonstrate a continued shortage of anesthesiology faculty and continued institutional support to keep these training programs financially viable.

Keywords: 1) Education: faculty; academic, shortage
2) Economics: medical center support
3) Statistics: survey

Implication Statement: United States anesthesiology training programs continue to have open faculty positions. The institutional support continues to grow averaging \$97,621/faculty in 2004, which is a 63% increase over the support in 2002.

INTRODUCTION

In the late 1990's there was a dramatic decrease in the number of medical students entering anesthesiology training programs in the United States (U.S.).(1) The entering residency class size, not only decreased to less than half its previous size, but half of those residents in training were international medical graduates (IMG). Since many IMG residents train in the U.S. on J-1 visas, they are required to return to their home country at the completion of their training, and therefore, cannot enter the U.S. workforce for at least two years.(2,3) Starting in the year 2000 it became evident that there was a significant national shortage of anesthesiologists that could persist for more than a decade. (2,3) This shortage of anesthesiologists affected not only community practice, but also the ability of academic training programs to recruit and retain faculty. (4-6) Competition for qualified anesthesiologists resulted in increasing salaries for faculty, which placed academic programs in financial jeopardy at a time when managed care had reduced professional fee income and academic medical centers (AMC) were also struggling to control costs. (4-9) In the fall of 1999, the Society of Academic Anesthesiology Chairs/Associate of Anesthesiology Program Directors (SAAC/AAPD) Counsel commissioned a white paper to be written to provide background information regarding these financial threats to the U.S. training programs.(5) Data for this report were derived from a variety of sources, including a survey of the U.S. anesthesiology training programs conducted in the summer of 2000 and presented at the fall 2000 SAAC/AAPD National Meeting. (4,5) Follow-up surveys have been conducted in the fall of 2001, 2002, and 2003; all have demonstrated a continued shortage of faculty and a progressive increase in financial support from their institutions. (6,10) The purpose of this current article is to report the results of the most recent follow-up survey (fall of 2004) and compare these data to those of the previous four years.

METHODS

For the past five years, email surveys have been sent to program directors of U.S. anesthesiology training programs. (10) The follow-up surveys conducted in 2001, 2002, and 2003 have focused on: open faculty positions, open certified registered nurse anesthetist (CRNA) positions, department financial margins, and the amount of institutional support received. In the previous surveys it was not determined whether the financial support from the institution included support for the salaries of CRNAs. Since the budgeting of CRNA salaries may occur under the hospital or the department, and may be funded independently or as a portion of the department's overall institutional support, it is important to clarify the accounting of these funds. With these additional data, the institutional support for faculty and academic programs can be determined. Therefore, the 2004 survey asked specifically if the institutional support includes funds used to pay for CRNA salaries and, if so, what is that dollar amount? (APPENDIX I) After their Fall 2004 meeting, SAAC/AAPD leadership requested that the total number of anesthesia units billed by a department per year, also be surveyed. (APPENDIX II) The first email survey was sent in September and email reminders were sent approximately every 2 weeks for the next 16 weeks to those who did not respond. The anesthesia unit survey was sent in November and email reminders were sent to nonresponders every two weeks for the next 12 weeks.

RESULTS

The surveys in APPENDIX I and II were distributed by email to 128 SAAC/AAPD member department chairs. An overall response rate of 73% (94/128) was achieved. The results are presented in Tables 1-6. The average department has 45 faculty and for 91% of those departments who have CRNAs, they have 25 CRNAs. (Table 1) There are an average of 3.3 open faculty positions in the 81% of responding

departments who have open positions. Of the 91% of responding departments who employ CRNAs, 73% had an average of 4.2 open CRNA positions. (Table 2) Overall, the departments' provide faculty with 16.1% nonclinical time (Table 6), where one day per week is considered 20%. (APPENDIX I) If faculty are not required to start clinical responsibilities until the afternoon, that pre-call day is considered nonclinical (academic) time.

From a financial funds flow perspective, U.S. anesthesiology training departments can be divided into three types: Academic Medical Center (AMC) Model programs are those with departments within medical schools; "budgeted departmental model" (Budgeted Model) are those in which departments are part of a larger clinical enterprise which manages the finances; and the "independent department model" (Independent Model) where the departments are structured like private practice groups. (6) The financial data for this report are from the AMC Model and Independent Model departments, since the financial data are unavailable in the Budgeted Model.

For the purposes of this survey a faculty full-time equivalent (FTE) is an anesthesiologist who is on the department's budget. (APPENDIX I) For the fiscal year ending June 30, 2004, 55% of departments responded that they had achieved a positive margin of \$949,386 (\$27,416/FTE) while 42% responded they had a negative margin of \$1,566,700 (\$35,521/FTE). (Table 3) These margins were determined after the inclusion of institutional support which averaged \$3,787,835 or \$97,621/faculty FTE. (Table 4, Figures 1a, 1b) For 36.6% of the respondents this support included funds used to pay CRNA salaries, which averaged \$1,888,111. Therefore, the institutional support for departments after CRNA support dollars are removed average \$3,210,295 or \$81,696/faculty FTE. (Table 4, Figures 1a, 1b) The majority

of this support is being provided by the hospital; average hospital support = \$2,968,068, medical school support = \$745,035, and support from other sources = \$1,064,207. (Table 5)

The average anesthesia unit value charge was \$75.96 and the average number of units billed by a department was 483,747 units or 11,954/faculty FTE. (Table 4)

DISCUSSION

Although there appears to be a continued shortage of anesthesiologists nationwide, data from this most recent survey reveal a slight decrease in open faculty positions per department from 3.7 in 78% of departments in 2003 to 3.3 open faculty positions in 81% of departments in 2004. This decrease in open positions is consistent with the results of the annual survey of the Society of Academic Anesthesiology Chairs (SAAC) which reported 192 open positions (or 2.4 positions/dept) in 2004 where there were 266 open positions (or approximately 3.1 positions/dept) for the survey in 2003. (2004 SAAC Salary Survey, personal communication with Rebecca Lovely, University of Florida Gainesville, FL) (8) This may be due to a greater availability of anesthesiologists or a larger percentage of graduating residents choosing an academic career. The progressive increases in academic salaries may make recruiting faculty easier. In the year 2000, according to the SAAC Salary Survey, an assistant professor paid at the 50th percentile received \$183,000/year. This increased to \$209,000 in 2002, \$226,000 in 2003, and \$242,821 in 2004. (8) Over the last 4 year period the average institutional support/FTE has increased from approximately \$34,000 to more than \$97,000. (Table 4, Figure 1b) This \$63,000 increase in institutional support is very similar to the salary increase of the average assistant professor over the same period of time. The salary increase found in the SAAC Salary Survey shows a similar trend as that found in the Association of American Medical Colleges (AAMC) and Medical Group Management Association (MGMA) Salary

Reports. Although both of these reports lag one year behind the SAAC Salary Survey reports because of the time associated with data retrieval and publication. (7-9) Although the average support for departments per faculty increased in the past year from \$85,607 to \$97,621, it is clear that in some departments a portion of the support has been used for CRNA salaries. It is unclear how much of the support to departments from previous years was attributed to CRNA salaries, but it is unlikely that the departmental support has decreased in 2004. It is more likely that a significant proportion (15 to 20%) of the support to departments in previous years had been associated with the support of CRNA salaries. From these most recent data, approximately one-third of the departments received support for CRNA salaries included in their overall departmental support, whereas two-thirds have CRNA salaries funded through another mechanism e.g. they are hospital employees. The largest portion of department support is provided by the hospital and has increased over the past 5 years.(Table 5) This willingness of the hospital to provide support to anesthesiology departments is most likely due to the hospital's financial imperative to maintain operating room productivity and revenues. Without anesthesiology faculty this could not be accomplished. It is also clear that there is great variability between institutions and departments in their financial status and institutional support. (Figure 1a.) These data are also not normally distributed with mean support well above the median. The institutional support per faculty FTE has a mean of \$97,621, a median of \$75,000, and a 25% and 75% range of \$37,467 and \$127,087. (Figure 1b., Table 4)

In addition to a slight decrease in the number of open faculty positions, it appears the average amount of academic time may have also increased slightly in the past year from 13.8% nonclinical time in 2003 to 16.1% in 2004, where one day/week is considered 20% time.(Table 6) The average anesthesia charge has increased only \$1.16 or 1.6% over the past year, where it had increased 19.5% between 2000 and

2003. This survey did not request any information regarding payor mix or collection rate. Since most payor reimbursements are unrelated to charges, these data should not be interpreted as significantly affecting department revenue.

The number of anesthesiology units billed per faculty may be only a crude measure of the ability of a faculty to generate professional fees sufficient to cover their expenses. The net income associated with that professional fee effort is to a much greater extent dependent on the payor mix of the patients cared for and the overhead associated with the practice. Neither of these crucial financial measures was within the scope of this follow-up survey. It has also been demonstrated that the number of anesthesiology units generated by a faculty member is not a good measure of faculty productivity. (11-14) It is a better measure of faculty and operating room (OR) utilization. (11-14) That is, if the ORs to which a faculty is assigned are well utilized by the surgical staff, then that faculty anesthesiologist will be able to generate more units, especially if there are more cases of shorter duration. (11-14) If faculty are assigned to out of OR locations, such as, radiology, electrophysiology, and labor and delivery then, although the faculty time is consumed, the ability to generate anesthesia professional fees is greatly reduced. Billable hours of anesthesia service may be a better measure of anesthesiologist productivity but that was also beyond the scope of this survey. (13,14) Anesthesiology units/FTE/year also does not account for faculty time and fees generated in non OR areas, such as, critical care units and pain management centers. These anesthesia unit data are provided here to give a rough guide of the relative utilization of anesthesiology faculty for OR services.

Survey data, in general, may misrepresent reality because of a small response rate, a skewed response population, or errors in the respondents understanding of the survey questions. The 73% response rate

of this current survey compares favorably with the 25%-31% response rate of the MGMA reports. (7-9)

The large response rate achieved in this survey is likely attributed to the fact that the respondent program directors were informed that they would receive the results of this survey at their national meeting and these results may be useful to them in managing their departments. In addition, because this is the fifth consecutive year of surveying the same population regarding a similar topic, it is likely that these data are at least consistent and potentially improved over the previous 4 years.

A critical number in this analysis is the faculty count, i.e. "employed FTE faculty anesthesiologist." (APPENDIX I) This was meant to be the number of employed faculty anesthesiologists, not their clinical commitment. If the individual filling out the survey misinterprets this question then all the subsequent data, which are normalized to the faculty FTE count, would be in error. The average number of faculty per department of 45.3 from this survey is similar to 43.2 faculty from the 2004 SAAC survey, providing some confirmatory data. All the results of the survey, as with all surveys, are dependent upon the respondents understanding what is being asked.

We conclude from this fifth survey that the U.S. anesthesiology training programs still require substantial support to maintain financial viability. The average department is receiving nearly \$82,000/faculty in institutional support after the expenses of CRNAs are removed. In spite of this support, on average, the departments continue to have a negative margin. It also appears that the faculty shortage in academic departments may be easing slightly, possibly due to increased salaries and a small increase in academic time.

REFERENCES

1. Grogono AW. National resident matching program results for 2004: slight decline in recruitment. *ASA Newsletter* 2004;68(5).
2. Schubert A, Eckhout G, Cooperider T, Kuhel A. Evidence of a current and lasting national anesthesia personnel shortfall: scope and implications. *Mayo Clin Proc* 2001;76:995-1010.
3. Schubert A, Eckhout G, Tremper KK. An updated view of the national anesthesia personnel shortfall. *Anesth Analg* 2003;96:207-14.
4. Tremper KK, Reves JG, Barker SJ et al. The financial environment of academic anesthesia. In: Lake CL, Johnson JO, eds. *Advances in Anesthesia*. Carlsbad, CA: Mosby, Inc. 2001;1-35.
5. Tremper KK, Barker SJ, Gelman S, et al. Surviving the perfect storm: the financial environment of academic anesthesia, October, 2000. White Paper Commissioned by Society of Academic Anesthesiology Chairs and the Association of Anesthesiology Program Directors (SAAC/AAPD). Available at: <http://www.asahq/aapd-saac/homepage.html>.
6. Tremper KK, Barker SJ, Gelman S, et al. A demographic, service, and financial survey of anesthesia training programs in the United States. *Anesth Analg* 2003;96:1432-46.
7. Medical Group Management Association Academic Practice Compensation and Production Survey for Faculty and Management. 2004 Report Based on 2003 Data. MGMA Center for Research, 104 Inverness Terrace East, Englewood, CO 80112.
8. SAAC Salary Survey, Personal Communication with Rebecca Lovely, Department of Anesthesiology, University of Florida, P.O. Box 100254, Gainesville, FL 32610.
9. AAMC Data Book: Statistical Information Related to Medical Education, January 2005, Faculty Compensation, Table K1. [Online] <https://services.aamc.org/Publications>.
10. Tremper KK, Shanks A, Sliwinski M, et al. Faculty and finances of United States anesthesiology training programs: 2002-2003. *Anesth Analg* 2004;99:1185-92.

11. Abouleish AE, Dexter F, Epstein RH, et al. Labor costs incurred by anesthesiology groups because of operating rooms not being allocated and cases not being scheduled to maximize operating room efficiency. *Anesth Analg* 2003;96:1109-13.
12. Abouleish AE, Prough DS, Whitten CW, Zornow MH. The effects of surgical case duration and type of surgery on hourly clinical productivity of anesthesiologists. *Anesth Analg* 2003; 97:833-8.
13. Miller RD. Academic anesthesia faculty salaries: incentives, availability, and productivity. *Anesth Analg* 2005;100:487-9.
14. Feiner JR, Miller RD, Hickey RF. Productivity versus availability as a measure of faculty clinical responsibility. *Anesth Analg* 2001;93:313-8.

Table 1. Faculty and Certified Registered Nurse Anesthetists (CRNA) Staffing.

	Mean \pm SD	High	Low	Median
Faculty (N=88)	45.3 \pm 25.4	132.60	8.0	40.88
CRNA (N=86) *	24.8 \pm 41	252.0	1.0	13.38

*91% of Departments have CRNAs

Table 2. Open Faculty and Certified Registered Nurse Anesthetist (CRNA) Positions

	2000	2001	2002	2003	2004
Open faculty positions (No.)	3.8	3.9	3.4	3.7	3.3
Number of faculty	35.8	37.6	38.9	39.7	45.3
Departments with open positions (%)	91.5	83.5	78.4	78.4	81
Open CRNA positions (No.)	4.0	4.4	3.6	3.9	4.2
Number of CRNA	17.6	*	*	25.1	24.8
Departments with open positions (%)	66.5	75.0	67.18	63.6	73

*2001 and 2002 surveys did not request these data.

Table 3. Department Margin Analysis Fiscal Years 2000-2004

Department	2000 (N=100)	2001 (N=97)	2002 (N=90)	2003 (N=90)	2004 (N=96)
Positive Margin	53% (n=35) \$1,817,299 \$50,481/FTE*	53% (n=44) \$577,666 \$15,202/FTE	65% (n=56) \$1,102,719 \$28,354/FTE	58% (n=47) \$636,338 \$15,908/FTE	55% (n=46) \$949,386 \$27,416/FTE
Negative Margin	44% (n=29) \$847,306 \$23,814/FTE	38% (n=20) \$840,400 \$21,491/FTE	33% (n=28) \$1,572,021 \$40,423	38% (n=31) \$1,704,139 \$42,603/FTE	42% (n=35) \$1,566,700 \$35,521/FTE
Total Margin	\$936,786 (n=66) \$37,308/FTE	-\$116,528 (n=69) -\$4,844/FTE	\$32,803 (n=86) -\$495/FTE	-\$460,760 (n=82) -\$14,759/FTE	-\$215,901 (n=84) -\$1,309/FTE
Response Rate	66.2%	72.5%	63.8%	65%	73%

*FTE = full-time equivalent

Table 4. Average Institutional Support, Anesthesia Unit Value, and Anesthesia Units Billed/Full-Time Equivalent (FTE)

Year	2000 (N=100) +	2002 (N=88)	2003 (N=90)	2004 (N=94)
Total Support	\$1,235,474 (n=77)	\$2,329,748 (n=46)	\$3,424,296 (n=70)	\$3,787,835 (n=85)
25% Median 75%	\$204,772 \$500,000 \$1,747,433	\$562,500 \$1,175,388 \$2,500,000	\$1,210,000 \$2,350,000 \$4,934,351	\$1,700,000 \$2,700,000 \$5,500,000
Support/FTE	\$34,319 (n=77)	\$59,906 (n=46)	\$85,607 (n=70)	\$97,621 (n=85)
25% Median 75%	\$9,366 \$18,669 \$54,282	\$14,464 \$30,223 \$64,284	\$30,067 \$70,684 \$133,413	\$37,467 \$75,000 \$127,087
Total Support Less CRNA Support*	†	†	†	\$3,210,295 (n=85)
25% Median 75%	†	†	†	\$1,318,093 \$2,397,220 \$4,491,252
Total Support Less CRNA Support/FTE*	†	†	†	\$81,696 (n=85)
25% Median 75%	†	†	†	\$31,250 \$63,750 \$100,361
Anesthesia unit value charge	62.60 (n=78)	◇	74.80 (n=76)	75.96 (n=79)
Anesthesia units/FTE	◇	◇	◇	11,954 (n=79)
25% Median 75%	†	†	†	\$8,458 \$11,156 \$13,566

+2000 support data only represents hospital support.

*36.6% of departments received an average of \$1,888,111 of support for Certified Registered Nurse Anesthetist (CRNA) salaries.

† 2000, 2002, 2003 surveys did not ask for specific CRNA support data.

◇ Data were not requested on these surveys.

Table 5. Itemized Institutional Support: Hospital, Medical School and Other

	2000 (N=100)	2002 (N=88)	2003 (N=90)	2004 (N=94)
Hospital Support	\$1,235,474 (n=77)	†	\$2,396,983 (n=73)	\$2,968,086 (n=81)
	†	†	18.6% (n=75)	14.87% (n=81)
Medical School Support	†	†	\$613,919 (n=75)	\$745,035 (n=81)
	†	†	5.4% (n=77)	5.56% (n=81)
Other Support	†	†	\$901,787 (n=70)	\$1,064,207 (n=80)
	†	†	8.36% (n=75)	4.85% (n=80)
Total Support	\$1,235,474 (n=77)	\$2,329,748 (n=46)	\$3,424,296 (n=70)	\$3,787,835 (n=85)

† 2000 and 2002 surveys did not ask for these data.

Table 6. Faculty Academic Time

	2000 (N=100)	2003 (N=90)	2004 (N=94)
Faculty Academic Time (%)	20.0 (n=80)	13.8 (n=84)	16.1 (n=87)

20% = 1 day/week

LEGENDS

Figure 1a. This figure presents total institutional support for anesthesiology departments from the years 2000 to 2004. For each year the high and low lines are the 90th percentile and 10th percentile, the edges of the boxes are the 75th and 25th percentile, and the line in the middle of the box is the median value. Note the box on the far right represents the institutional support to the department with the CRNA salary support subtracted.

Figure 1b. This figure presents the total institutional support per faculty anesthesiologist FTE from the years 2000 to 2004. For each year the high and low lines are the 90th percentile and 10th percentile, the edges of the boxes are the 75th and 25th percentile, and the line in the middle of the box is the median value. Note the box on the far right represents the institutional support per faculty FTE with the CRNA salary support subtracted.

**Society of Academic Anesthesiology Chairs/Association of Anesthesia Program Directors
(SAAC/AAPD) 2004 Follow-Up Survey
Please Fax responses to: Amy Shanks at 734-763-8125**

Note: All information is confidential. The fax number is the private fax of Amy Shanks and the information submitted will only be viewed by Amy.

Name: _____

Institution: _____
(This information is only used for tracking purposes. It is never reported with the results.)

I. Staffing

How many employed FTE faculty anesthesiologists do you have? _____
(These are faculty anesthesiologists who are on your budget)

How many open faculty positions do you have? _____

How many CRNAs do you have? _____

How many open CRNA positions do you have? _____

II. Department Finance (for fiscal year ending 6/30/04)

What is your department's total budget? \$ _____

Was your department margin* positive? () or negative? ().
By how much? \$ _____ Percentage of total budget _____ %
(*not including gifts or investments)

III. Departmental Financial Support from Hospital, Medical School or other sources.

What is the annual institutional support for your department from all sources (hospital, medical school, state, etc*) \$ _____
(*this does not include pro-fee income, research grant, gift or endowment income.)

How much from the Hospital? _____
Percent of total budget _____ %

How much from the Med School? \$ _____
Percent of total budget _____ %

How much from Other sources? \$ _____
Percent of total budget _____ %

Does your institution support include funds which are used to pay for CRNA salaries?
Yes () No ()
If yes, how much? \$ _____

IV. Faculty Academic Time

What is the average amount of non-clinical (academic) time per faculty, not counting the day after in-hospital call? (one day per week = 20%). _____ % (for this calculation, if your faculty start late on the day they are on in-hospital call, count this as an academic day)

If your faculty start late on the day of in-hospital call, do you ordinarily count this day as an academic day? Yes () No ()

V. Unit Value Charge

What is your unit value charge for anesthesia? \$ _____

Thank you for taking the time to complete this survey.

KKT:as:11/02/04

Follow-Up Question to SAAC/AAPD Sent via Email on November 17, 2004:

It has become very important to know how many units per faculty are being billed by each of our departments. Since the rest of our medical schools and institutions use RVUs (relevant value units) and for the vast majority of our income we use anesthesia units, it is difficult for us to compare ourselves with other specialties. Therefore, data that compares us amongst ourselves can be very valuable. Please answer the following question:

How many anesthesia units did you bill last year, (July 1, 2003-June 30, 2004)? _____
total units.

For example, the Department of Anesthesiology at the University of Michigan billed 737,328 total units, (total units = base units and time units).

As before, hit the reply to message button and type your number in the space provided. You will receive this information along with an update of all the other responses in the near future.

Thank you.

Kevin K. Tremper, PhD, MD
Robert B. Sweet Professor and Chair
Department of Anesthesiology
University of Michigan

Figure 1a. Total Institutional Support

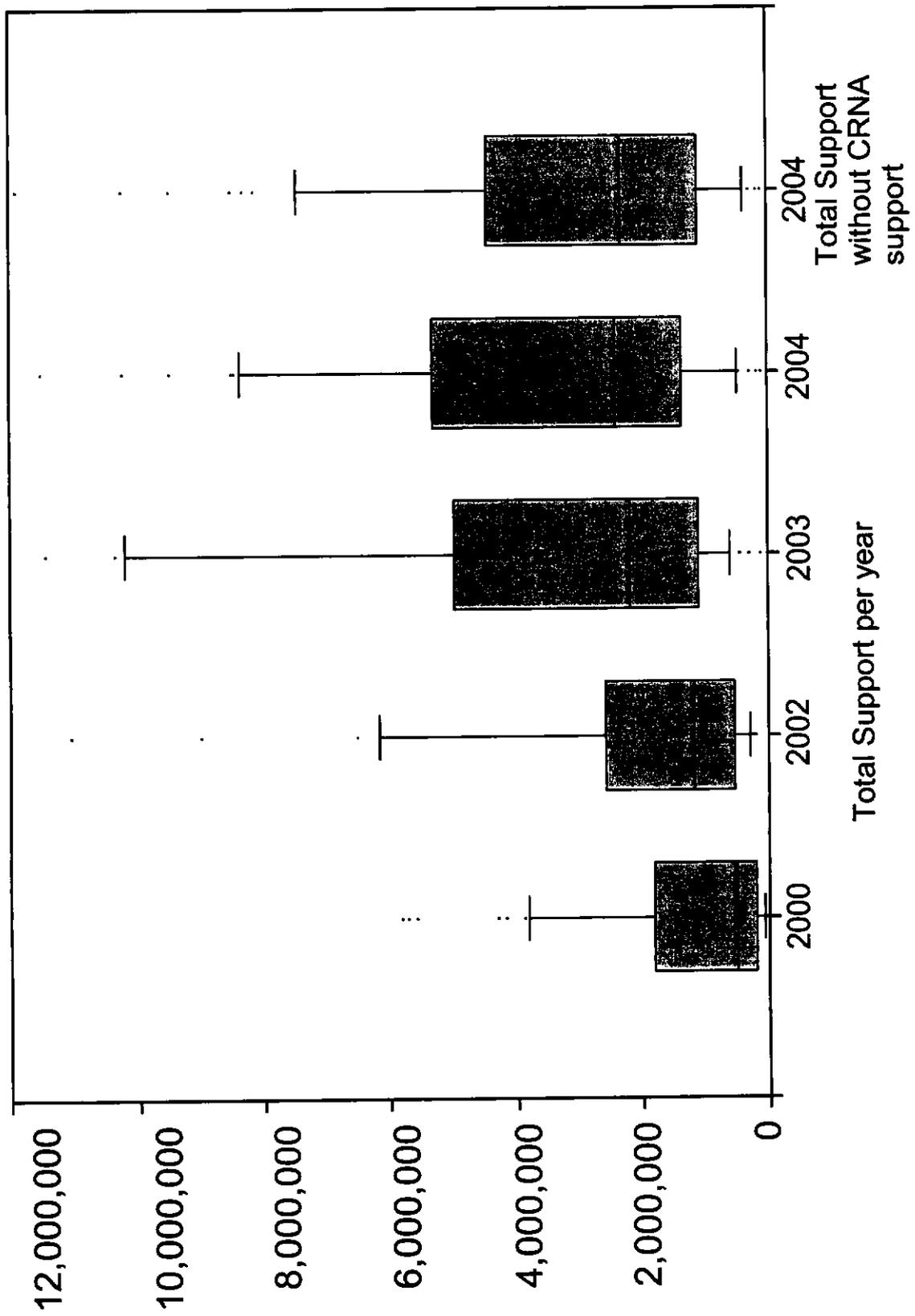
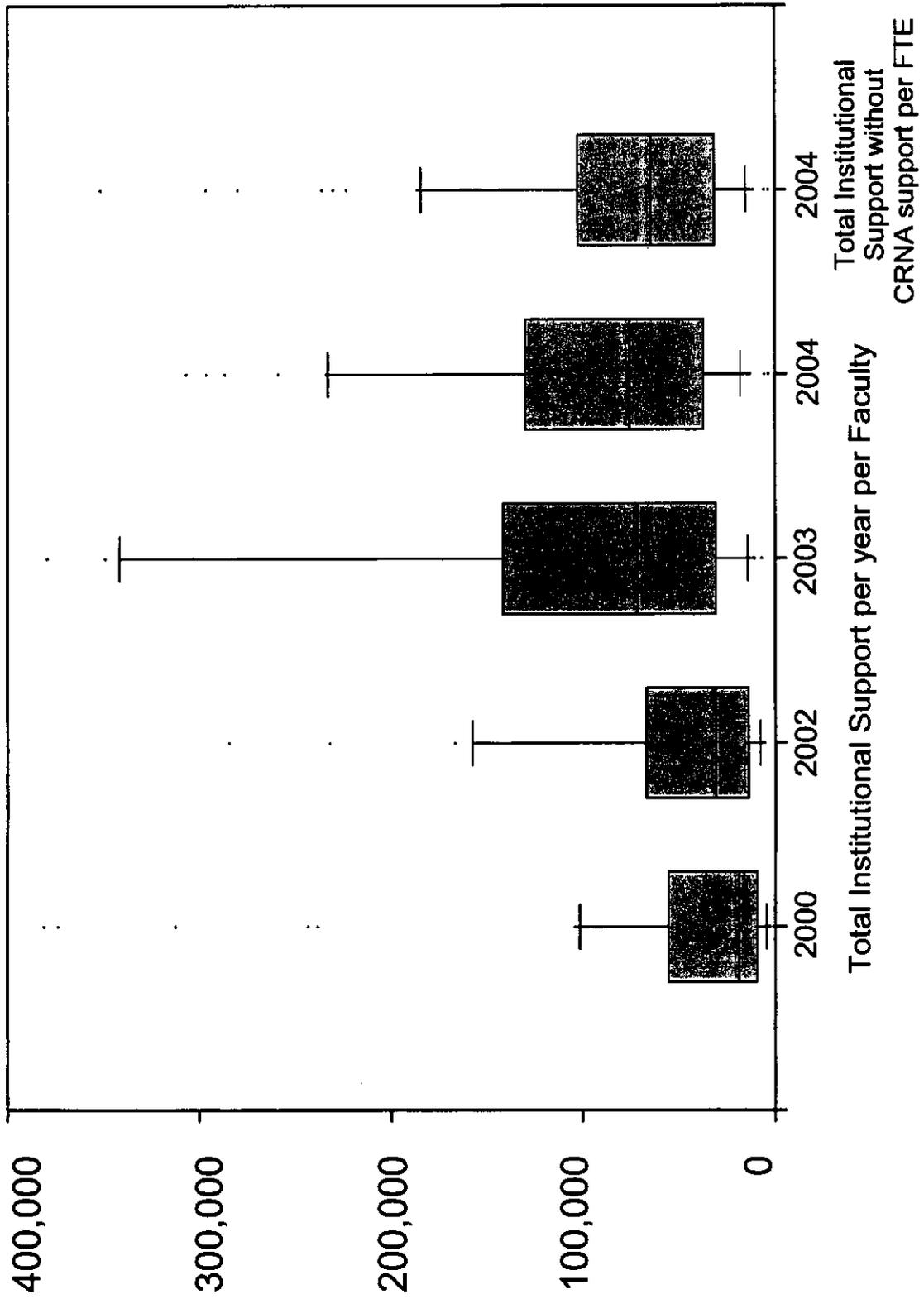


Figure 1b. Total Institutional Support per Faculty



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VERNA RUVALCABA
482 Kay Mar Way
Santa Rosa, CA 95401-5013
(707) 526-0269

SEP 14 2005

September 7, 2005

Department of Health and Human Services
Attn: CMS-1052-P
P. O. Box 8017
Baltimore, MD 21244-8017

Ladies and/or Gentlemen:

Re: Medicare Payments to Doctors
Sonoma County, California

This will refer to the proposal that Medicare reimbursement rates to doctors in Sonoma County be raised by about 8 percent. Enclosed is a copy of my letter to Congresswoman Lynn Woolsey dated August 6 which is self-explanatory.

One side that I have not seen mentioned is participation by senior citizens themselves.

While it is true that there are many senior citizens existing on Social Security and not much else, there are many more who are receiving good pensions, plus Social Security and other income. I believe that a good percentage of them would be willing to help "carry the load" if it is clearly explained to them that doctors are opting out and/or refusing to take new Medicare patients. Doctors, like anyone in business, do have overhead expense.

It may or may not necessitate some kind of a public relations program, but once the seniors realize that this would be purely voluntary, I don't see why they would object.

This is all just off the top of my head, but I'm offering it for whatever it's worth. This country should not have problems like this.

Very truly yours,

Verna Ruvalcaba
Verna Ruvalcaba

C P C I

Attention

395

CMS-1502-P

I live in the County of Santa Cruz, Ca. and
urge you to change our County from
rural (which it is not) to urban.

SEP 14 1998

Seniors have a hard time finding
Doctors to take them because Medicare
doesn't re-emburse them enough.

Property here is very expensive and
so it is hard to keep medical
personel when they can get more
money just 20 miles away.

I have written to you before
urging you to change our area.

As we grow older (and you will
to) its important to remember the
needs of seniors and their need
for good medical care.

Noma Hardwick



Noma Hardwick

687 Paradise Park
Santa Cruz, CA 95060-0700



SEP 14 2005

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Thomas J. Conahan, M.D.
Associate Professor

Department of Anesthesia

September 6, 2005

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P/TEACHING ANESTHESIOLOGISTS
P.O. Box 8017
Baltimore, MD 21244-8017

Dear Dr. McClellan:

I am an academic anesthesiologist at the University of Pennsylvania Medical Center. This letter is a protest against the Centers for Medicare and Medicaid Services policy regarding Medicare payment to teaching anesthesiologists.

When a surgical colleague is working with residents in two overlapping operations, he is paid the full Medicare reimbursement for both operations. I am not. Academic anesthesiologists are penalized 50% of the already inadequate Medicare payment for their services when teaching resident physicians in two overlapping cases. This penalty is neither reasonable nor fair.

The number of anesthesia residency programs capable of turning out the teachers of the next generations of anesthesiologists is shrinking, in large part because of financial pressures. The Medicare penalty for teaching anesthesiologists is a significant contributor to the financial woes of academic anesthesiology departments.

Please end the penalty for being a teaching anesthesiologist. My surgical and internal medicine colleagues are able to claim full Medicare reimbursement for concurrent cases. Allowing academic anesthesiologists to do the same will allow us to educate the upcoming generation of physicians in anesthesia who will care for the rapidly growing population of Medicare recipients.

Sincerely yours,

Thomas J. Conahan, M.D., M.S. Ed.

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College of Medicine
Department of Anesthesiology



SEP 1 11 2005

P.O. Box 245114
Tucson, AZ 85724-5114
(520) 626-7221
FAX: (520) 626-6943

September 1, 2005

Centers for Medicare & Medicaid Services
Department of Health and Human Services
ATTN: CMS-1502-P
P.O. Box 8017
Baltimore, MD 21244-8017

Dear Dr. McClellan:

I am writing to you to ask for your assistance in our efforts to fix the flawed Medicare anesthesiology teaching payment rule. As academic "teaching" anesthesiologists, we were deeply disappointed that changes to the Teaching Rule (CMS-1502-P) were not included in the August 1, 2005 version of the Medicare Fee Schedule for 2006. We feel that the current Medicare teaching anesthesiologist payment rule is unfair and unsustainable.

As you may be aware, University Medical Center in Tucson, Arizona is the only trauma center located between Phoenix and the U.S. - Mexico border. As academic physicians, we manage patients with complex and difficult health issues. Many of these patients are referred to us by community physicians and facilities that feel unable to treat the patient adequately. As "teaching" anesthesiologists, we train resident physicians to care for these sick and elderly individuals. Our mission is to train resident doctors so that they are able to return to their communities and provide the same level of care. As academic physicians, we also participate in research and developing standards and guidelines that benefit both our patients and the anesthesiology community.

We, as an academic department, are under significant stress as we try to maintain balance between the provision of clinical care, teaching and research. The Medicare Teaching Rule (CMS-1502-P) unfairly singles out anesthesiologists who remain in academic institutions. A surgeon, working in the same operating room, may supervise residents in two overlapping operations and collect 100% of the fee for each case from Medicare. An internist may supervise residents in four overlapping outpatient visits and collect 100% of the fee for each when certain requirements are met. A teaching anesthesiologist will only collect 50% of the Medicare fee if he or she supervises residents in two overlapping cases. This burden is carried in addition to the current Medicare anesthesia conversion factor that is less than 40% of prevailing commercial rates. In our institution, 62% of our patients are insured by federal payers.

Quality medical care, patient safety and an increasingly elderly Medicare population demand that the United States have a stable and growing pool of physicians trained in anesthesiology. In order to train these doctors to provide the excellent care that Medicare patients have come to expect, "teaching" anesthesiologists must be retained and not driven out of academic medicine because salaries cannot be supported by department budgets. We are asking for your support to protect our academic anesthesiology program. Please correct the anesthesia teaching payment policy.

Thank you.

Robert Loeb, M.D.

cc: ASA Board of Directors
Sen. John McCain
Sen. Jon Kyl

September 7, 2005

SEP 11 2005

RE: CMS-1502-P

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P
PO Box 8017
Baltimore, MD 21244-8017

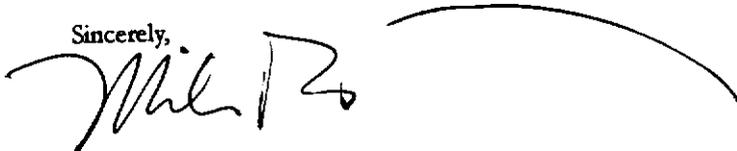
SUBJECT: TEACHING ANESTHESIOLOGISTS

Realizing that change is needed in the academic setting, it is imperative that corrections be made to the current reimbursement system.

- ❖ Medicare's restitution for teaching anesthesiologists is unjustifiable, creating an inequity in the operating room and minimizing work completed by both the resident and faculty member.
- ❖ Realizing patient safety a consideration, faculty members are lending themselves equally to two residents and providing the same amount of service as if working in two separate settings as one individual.
- ❖ Manpower shortage incurred due to the ill-conceived notion of Medicare's remuneration policies. A burden has been placed on the department, forcing the hospital to evaluate its financial endorsement.
- ❖ Medical schools collections should substantially sustain their own practice and the ancillary hospital is reluctant to contribute to the department. Causing the number of residency programs to a very minimum in our country due to funding shortages in the private and public sectors.
- ❖ The anesthesiologist is in the hospital twenty-four hours a day for trauma care, obstetrics coverage, and elective surgeries that run past the normal work hours. Being the backbone of most hospital settings, anesthesiologists are not in a position to "pick and choose" their patient mix.
- ❖ Lack of Medicare's support, teaching institutions will need to evaluate their commitment to anesthesia programs, forcing a change in the current medical setting which could be more costly for hospitals and patients.

The decision lies in your hands. It is imperative that all aspects be considered in your decision. A change is needed today!

Sincerely,



Jon Michael Badgwell, M.D., F.A.A.P.
Professor
Program Director

cc: American Society of Anesthesiologists

3601 4TH STREET
MS 8182
LUBBOCK, TX 79430

TELL MEDICARE TO CORRECT REIMBURSEMENT IN SONOMA COUNTY

One-time Opportunity to Change Federal Guidelines

Sonoma County has suffered under the strain of inadequate medical compensation for more than a decade. Several medical groups have gone bankrupt, Health Plan of the Redwoods has shut down, employers have faced significant increases in health insurance premiums, and many doctors have left the county because of low reimbursement.

In addition:

- Medical costs in Sonoma County have risen much faster than other areas and are, on average, 8% higher than similar counties.
- Among cities with a population of 100,000 or more, Santa Rosa is sixth in the United States for the highest percentage of people 85 and older.
- Seniors (60 and older) represent 16.6% of total population in Sonoma County with a projected rate of change of 196% from the year 2000 to 2020.

And, amid that astounding growth in elder population, Sonoma County has the lowest Medicare reimbursement rate in California:

- The number of practicing physicians in Sonoma County has not kept pace with local population growth – over a seven-year period (1995-2002) the population increased 13 percent and the number of physicians practicing increased by only 4 percent.
- In July 2005, six out of 10 Sonoma County primary care physicians were NOT accepting new Medicare patients.
- Many physicians are leaving our county to practice where reimbursement is more favorable.

The result: thousands of patients, particularly those on Medicare or without insurance, are having trouble accessing health care.

Medicare has proposed a new rule that would increase the reimbursement rate for Sonoma County by 8%. This proposal will bring Sonoma County back in line with current Medicare reimbursement standards, which will help stabilize our medical community.

How can you support Medicare's proposal? Sign a petition or write a letter to Medicare in support of their proposal. Sample letters are available online at www.scmag.org or call the Sonoma County Medical Association at (707) 525-4375. Comments must be received at Medicare by September 30, 2005.

Bring me copy making for Duke Noble copy
Let your voice be heard!

Tell Medicare to correct reimbursement in Sonoma County NOW!

Send your letter, along with two copies to:

Centers for Medicare & Medicaid Services
 Department of Health and Human Services
 Attention: CMS-1052-P
 PO Box 8017
 Baltimore, MD 21244-8017

Be sure to mail your letter by September 22 to meet the September 30 deadline.

*I don't blame out patients
 Doctor here for being
 angry. This caused a few
 times second with other
 Dr. which gives you
 often times you
 answers you
 PLEASE*

This ad has been paid for by Redwood Regional Medical Group in support of the Sonoma County Medical Association's efforts to promote awareness of this important issue.

Signed: *Jessie Gay Sampson*

SEP 13 2005 379

SEP 13 2005

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Sept. 8, 2005

I am requesting that the
correct re-embursement for the
wonderful Sonoma County doctors still
treating Medicare patients be implemented
expediently.

We have too few left & many will
be forced to leave as they are losing money!

Sincerely,

Donna Asante

* Correct re-embursement in Sonoma
County NOW

Centers for Medicare
Dpt Health & Human Services
Box 8017
Baltimore MD 21244-8017

Re: GPCI

to Whom it may concern.

Our Santa Cruz area, needs to
make from Medicare, comparable
payments to physicians as other
counties in the S. So Bay area.

Please, do not discriminate,
we need as good physicians
as any one else,

Gratefully

H. Gunn.

Edward J. White
 Anne L. White
 3585 Round Barn Blvd. #101
 Santa Rosa, CA 95403

SEP 13 2005

September 10, 2005.

To: GPCI

Attention: CMS 1052P

Subject: To correct Medicare Reimbursement
 in Sonoma County, California

To whom it may concern:

A very serious thing happened to me
 This week.

Two young doctors told me they could
 not accept positions in Santa Rosa with
 two doctors who plan to retire.

WHY
 1. The rate of Medicare Reimbursement
 is so low in Sonoma County they could
 not:

- A. Pay off existing educational loans.
- B. Pay to rent office space.
- C. Pay for necessary equipment.
- D. Pay the rent on a home.
- E. Qualify to buy a home.
- F. Pay salary to office help.

2. The Senior Population in Sonoma County, California is expected to increase dramatically in the next few years.
3. Already more & more primary care doctors cannot accept new medicare patients
4. Already more of our established physicians are leaving Sonoma County, California to practice where medicare reimbursement is more favorable.

Medicare reimbursement in Sonoma County must be corrected now.

Sincerely,

Anne R. White

Anne R. White

707-545-1564

3230 Nielsen Rd.
Santa Rosa CA 95409
Sept. 7, 2005 283

Medicare Proposal,
to whom this may concern

SEP 15 2005

Dear Sir or Madam,

For many years Santa Rosa and
Sonoma County have suffered from
inadequate medical compensation.

I am highly in favor of your
8% increase proposal & hope
this materializes for our commu-
nity.

Thank you for considering
my letter of support.

Dorothy Wallstrom
age 85



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County of Santa Cruz

BOARD OF SUPERVISORS

701 OCEAN STREET, SUITE 500, SANTA CRUZ, CA 95060-4069
(831) 454-2200 FAX: (831) 454-3262 TDD: (831) 454-2123

SEP 15 2005

JANET K. BEAUTZ
FIRST DISTRICT

ELLEN PIRIE
SECOND DISTRICT

MARDI WORMHOUDT
THIRD DISTRICT

TONY CAMPOS
FOURTH DISTRICT

MARK W. STONE
FIFTH DISTRICT

September 6, 2005

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1502-P
P.O. Box 8017
Baltimore, MD 21244-8017

RE: GPCI'S/PAYMENT LOCALITIES

Dear Sirs:

I'm writing on behalf of my constituents in Santa Cruz County, California to urge you to support the proposed revision to the Physician Payment Localities published recently. I know from personal experience that the current placement of Santa Cruz County in Payment Locality 99 is doing significant harm to our local health care system.

Although expenses are extremely high for medical providers in Santa Cruz County, they are reimbursed as though they were operating in a lower cost, rural environment. The proposed rule removes Santa Cruz and Sonoma Counties from Payment Locality 99 and assigns them to unique localities which more accurately reflect the reality of providing medical care in those two counties. The proposed adjustment is appropriate and fair and will help rebuild and maintain our healthcare system.

Thank you for your consideration of this important issue.

Very truly yours,

ELLEN PIRIE, Supervisor
Second District

EP:lg

3472C2

SCOD

CMS-1501-P-28

385

Submitter :
Organization :
Category : Individual

Date: 08/25/2005

1502.7

Issue Areas/Comments

GENERAL

GENERAL

SEP 15 2005

I am a patient who suffers from cardiovascular disease and am grateful that my current physician has purchased a device (BioZ) to help manage my disease. It has been brought to my attention that Medicare is proposing to reduce the amount paid to physicians for this service, Thoracic Electrical Bioimpedance as well as many of services. My physician is questioning whether he can continue to perform this service if the payment changes. I strongly encourage you to reconsider this reduction. I can attest to how valuable this test is.

Date: 08/19/2005

Submitter : Dr.
Organization : Dr.
Category : Physician
Issue Areas/Comments

1502
JK

SEP 15 2005

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GENERAL

GENERAL

Date: August 16, 2005
To: Centers for Medicare and Medicaid Services
From: Alexander Volfson, M.D.
Re: TEACHING ANESTHESIOLOGISTS RULE

I am writing to urge a change in payment policy for teaching anesthesiologists. The current Medicare teaching anesthesiologist payment rule is unwise, unfair and unsustainable. Quality medical care, patient safety, and an increasingly elderly Medicare population, demand that the United States have a stable and growing pool of physicians trained in anesthesiology.

Anesthesiology teaching programs are suffering severe economic losses that cannot be absorbed elsewhere. Academic research in anesthesiology is increasingly difficult to sustain, as department budgets are broken by this arbitrary Medicare payment reduction. The current Medicare payment policy is unfair.

The CMS anesthesiology teaching rule must be changed to allow academic departments to cover their costs. It is not fair, and it is not reasonable. Please recognize the unique delivery of anesthesiology care and pay Medicare teaching anesthesiologists on par with their surgical colleagues.

Sincerely,

Alexander Volfson, M.D.
Resident in Anesthesiology
Weill Cornell Medical College
New York Presbyterian Hospital

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SEP 15 2005

September 14, 2005

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1502-P
Mail Stop C4-26-05
7500 Security Blvd.
Baltimore, MD 21244-1850
Sent by express/overnight mail

Re: 42 CFR Part 405

As the president of the Academy of Medicine of Cleveland/Northern Ohio Medical Association (AMC/NOMA), an organization representing more than 4,000 physicians in Northeastern Ohio I am writing to comment on the Medicare Program; Revision to payment policies under the physician fee schedule for calendar year 2006; proposed rule.

It is my understanding that under current law, the Centers for Medicare and Medicaid Services (CMS) is required to adjust payments to physicians based on a formula that ties reimbursement changes to the gross domestic product. Under that formula – physician payment would be cut an estimated 4.3 percent in 2006. The Sustainable Growth Rate (SGR) formula that is used by CMS to determine the Medicare physician payment updates is clearly flawed. The underlying flaw of the SGR formula is the link between the performance of the overall economy and the actual cost of providing physician services. The medical needs of individual patients are not related to the overall economy.

Using the current formula, Medicare is projected to impose physician payment cuts of 26 percent over six years beginning in 2006, while the cost of running a practice and caring for patients increases 15 percent. From 2006-2014 – Medicare payments in Ohio would be cut by \$4.97 billion. For physicians in Ohio, the cuts over this period will average \$20,000 per year for each physician in the state. It is projected that Medicare physician payment rates in Ohio would be cut by more than \$101 million in 2006.

All patients will be adversely affected by these proposed payment changes because Medicaid and private insurers use Medicare rates as a resource for their reimbursement rates. In addition, of all of the providers serving Medicare patients, only physicians are being subjected to lower payments in the CMS proposed rule. Data from CMS confirms that over the next seven years, inpatient hospital payments are projected to rise 32 percent while payments to physicians will be reduced by 31 percent.

The AMC/NOMA realizes that ultimately the administration and Congress will have to act in order to replace the SGR, however, CMS and its' administrators have the ability to review comments from physicians, physician organizations and other healthcare providers regarding the proposed payment and policy changes and try to find ways to improve physician payment without adding to overall Medicare costs. For example, CMS includes the cost of physician-administered drugs in its calculations of Medicare spending for physician services, and drug spending consumes an ever-growing share of the SGR target and is a major factor in projected pay cuts. CMS should consider working with the administration to remove drug costs from the SGR, which would significantly reduce the costs as well as encourage Congress to eliminate the SGR and adopt the same payment updates that are used for hospitals and other Medicare providers.

The AMC/NOMA recently surveyed our members asking what they would do if the Medicare proposed payment rates were implemented in 2006. More than 38% of those responding indicated that they would close their practice to new Medicare patients, and more than 20% indicated they would stop seeing Medicare patients altogether. Couple that information with the fact that a physician shortage has been predicted in the next decade – and it is easy to see that patient care will be compromised.

For the sake of our patients and profession, the members of the AMC/NOMA ask that the proposed payment changes be carefully reviewed. If the proposed payment changes are implemented, Medicare payment rates in 2014 will be little more than half what they were in 1991, after adjusting for practice cost inflation. As it is, Medicare payments already lag behind increases in practice costs. The AMC/NOMA believes that the CMS proposed payment changes for 2006 would adversely affect how Medicare patients will be cared for in the future. If you have any questions regarding our comments please feel free to contact me through the AMC/NOMA offices at 216-520-1000.

Sincerely,



George E. Kikano, MD
President
The Academy of Medicine of Cleveland/Northern Ohio Medical Association



MASSACHUSETTS
GENERAL HOSPITAL



SEP 15 2005
HARVARD
MEDICAL SCHOOL

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Zero Emerson Place, Suite 3A
Boston, Massachusetts 02114
Tel: 617.726.9464, Fax: 617.724.6130
E-mail: harris@helix.mgh.harvard.edu

VIA FEDERAL EXPRESS

Gordon J. Harris, Ph.D.
*Director, Radiology Computer Aided
Diagnostic Laboratory
Director, 3D Imaging Service
Associate Professor of Radiology
Harvard Medical School*

September 13, 2005

Mark McClellan, M.D., Ph.D., Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P
CMS-DHHS
Room C4-26-05
7500 Security Blvd
Baltimore, MD 21244-1850
(410) 786-7197

Re: CMS-1502-P: Comment on decreased technical RVU reimbursement rates for 3D services (CPT 76375) as proposed on August 8, 2005, for the 2006 Medicare Physician Fee Schedule

Dear Administrator McClellan:

Massachusetts General Hospital (MGH) and its colleagues in diagnostic radiology appreciate the opportunity to submit comments in response to the Centers for Medicare and Medicaid Services' (CMS's) proposed revisions to the Medicare Physician Fee Schedule (MPFS) for 2006, as published in the *Federal Register* (70 Fed. Reg. 45764) on August 8, 2005.

We are submitting this comment letter to do the following:

- provide background on our 3D Imaging Service, its clinical applications, and its resource use;
- highlight the historical application of the add-on Current Procedural Terminology (CPT) code 76375: *coronal, sagittal, multiplanar, oblique, 3-dimensional and/or holographic reconstruction of computerized tomography, magnetic resonance imaging, or other tomographic modality*;
- and, explain our recommendation for CMS to maintain the technical component (TC) relative value units (RVUs) for this code in 2006 at the 2005 levels to appropriately reflect the additional practice expenses associated with add-on code CPT 76375.

BACKGROUND ON OUR FACILITY'S 3D DIAGNOSTIC RADIOLOGY CAPABILITIES

Our 3D Imaging Service performs 3D reconstructions (billed under CPT 76375) on clinical exams for approximately 40-50 patient cases each day. We provide a large portion of our services to hospital patients as well as a significant number of analyses for freestanding facilities that bill under the MPFS.

MGH established its 3D imaging service to meet the clinical need of the community. Image reconstructions require a specialized staff member and specialized equipment to process images for proper clinical interpretation, and these images are often urgently awaited for treatment decisions and surgical planning. The proposed changes in reimbursement for 3D reconstructions impact our lab as well as those at many other institutions.

CLINICAL BENEFITS OF 3D RECONSTRUCTION

Tomographic imaging modalities such as computerized tomography (CT), magnetic resonance imaging (MRI), and ultrasound (US) produce cross-sectional views of the body. However, when viewing the original tomographic scan, all that is seen are individual cross-sectional views through the anatomy of interest.

In comparison, by creating a volume of image data from the original tomographic scan and performing 3D processing on specialized computer workstations, comprehensive views of entire anatomical systems can be visualized in full detail. Images produced using 3D reconstructions are used routinely for both clinical diagnosis and detailed surgical planning.

ADDITIONAL RESOURCES REQUIRED FOR 3D

3D imaging requires additional resources compared to a standard tomographic exam. At our facility, a highly skilled technologist will spend 20-60 minutes processing a 3D exam to produce optimal views of all the major anatomy and pathology to be evaluated. The technologist must be an expert in the anatomy to identify the proper views to be focused upon, the scanning techniques to recognize artifacts, and the complex operations of the computer software to create the images. Furthermore, the computer workstations are expensive and complex machines that must seamlessly integrate with the image network, scanners, and picture-archive and communication system (PACS). Each of these 3D workstations costs between \$70,000 and \$200,000.

CHANGE IN TC-RVUs FOR 3D CODE CPT 76375 IN 2006 MPFS PROPOSED RULE

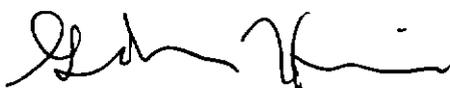
In 2005, 3D imaging with CPT 76375 was assigned a technical (TC) RVU value of 3.72, with a conversion factor of \$37.90. In the 2006 proposed rule, the TC-RVU value for CPT 76375 was reduced to 3.05, with a conversion factor of \$34.50. The net result is a decrease in reimbursement for CPT 76375 of over 25%. Under the proposed 2006 MPFS rule, labs that specialize in performing 3D imaging reconstruction will experience reduced reimbursement of over 25% for this service with CPT code 76375. At our facility, the reimbursement for 3D post-processing from the add-on CPT code 76375 is always applied to support the additional expense of the image-processing component of the 3D exams, including the costs of the specialized staff and equipment.

CONCLUSION AND RECOMMENDATION TO CMS

We understand that coding decisions and RVU allocations for physician fees are complex and that CMS must be judicious. At the same time, we believe that our case is strong and should not be controversial. We hope that CMS will act favorably on our suggestions regarding the adjustment of the TC RVUs for CPT 76375 to reflect the additional practice expense TC-RVUs associated with image post-processing for these 3D services. We recommend that CMS maintain the TC-RVU value for CPT 76375 at 3.72, consistent with the 2005 level. We hope that this correction can be implemented for the 2006 final rule.

I realize that some of these issues may require more information, which I would be happy to provide on request. If you have any questions regarding these comments, please do not hesitate to contact me at (617) 726-9464.

Sincerely,



Gordon J. Harris, Ph.D.
Director, 3D Imaging Service, Department of Radiology,
Massachusetts General Hospital



**Drummond
Medical
Group, Inc.**

1111 North China Lake Boulevard
Ridgecrest, California 93555-3196
(760) 446-4571

569150 389

Working for your better health

SEP 15 2005

- Allergy*
ALAN E. GORENBERG, MD
- Cardiology*
AVINASH M. MONDKAR, MD
- Dermatology*
JEFFREY R. GUNTER, MD
- Family Practice*
D. JAMES DIXON, MD
DAVID P. LUSK, MD
- General Surgery*
VICTOR GONZALEZ, MD
PAUL E. STEMMER, MD
- Internal Medicine*
LAWRENCE N. COSNER, JR., MD
PEDRO L. FARINHA, MD
DOUGLAS E. ROBERTS, JR., MD
CORNELIS VANDERHOEK, MD
- Obstetrics/Gynecology*
LOIS A. JENSEN, MD
RICHARD P. KAROLL, MD
LASZLO MURRAY, JR., MD
- Ophthalmology*
VICTOR A. HOLMES, MD
- Otolaryngology*
RUWANTHI CAMPANO, MD
- Pediatrics*
MARCIA A. MICHALIK, MD
- Podiatry*
HUY DAVID NGUYEN, DPM
- Nurse Practitioner*
HELAINÉ M. BOGGS, RN, NP-C
- Physician Assistant*
APAMA K. CHILDERS, PA

Mark B. McClellan, MD, PhD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Subject: August 8, 2005 -- Proposed Rule: CMS-1502-P

Dear Dr. McClellan:

On August 8 of this year, CMS proposed new physician payment rules for 2006, including the move of two California counties (Santa Cruz and Sonoma) out of payment Locality 99—the “Rest of California”—thereby reducing the reimbursement to the remaining Locality 99 counties. Many of those impacted, including Kern in which my practice is located, would be further adversely impacted, as we already suffer an artificial reduction due to averaging with lower-cost counties. Thus, we would receive a further 0.4% (GPCI) reduction, over-and-above the anticipated 4.7% reduction due in 2006 due to the flawed sustainable growth rate (SGR) formula.

As the clinic medical director in a rural, geographically isolated area, I see on a daily basis the difficulties engendered by lack of access to medical care. Such reductions in reimbursement will further complicate our ability to recruit physicians to our already-underserved area, and may well cause some of those already practicing here to curtail or eliminate the current ‘open practice’ model of taking all Medicare and Medi-Cal (the California version of Medicaid) patients. This would further reduce access, and patient care would suffer.

We drastically need the broken SGR formula fixed, as it alone may well result in the reduced access mentioned above. Given this backdrop, it is vital that we do not worsen the situation by a reduction in GPCI as well.

Thank you for your time and consideration. I am,

Sincerely,

Lawrence N. Cosner Jr., MD
Medical Director, Drummond Medical Group

September 13, 2005

Hector Vila, Jr., M.D.

*Service Chief, Anesthesiology
H. Lee Moffitt Cancer Center
Program Leader, Anesthesiology
Department of Interdisciplinary Oncology
Assistant Professor Oncology and Anesthesiology
University of South Florida College of Medicine*

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P/TEACHING ANESTHESIOLOGISTS
P.O. Box 8017
Baltimore, MD 21244-8017

Dear Dr. McClellan:

I am writing as an Academic Anesthesiologist at the H. Lee Moffitt Cancer Center in Tampa, Florida to urge the Centers for Medicare and Medicaid Services (CMS) to change the Medicare anesthesiology teaching payment policy.

Our institution, trains both Anesthesiology Residents and Certified Registered Nurse Anesthetist (CRNA) students and we therefore are fully aware of the economic impact of Medicare's discriminatory payment arrangement. It applies only to anesthesiology teaching programs, and has had a serious detrimental impact on the ability of our anesthesiology residency program to retain skilled faculty and to train the new anesthesiologists necessary to help alleviate the widely-acknowledged shortage of anesthesia providers -- a shortage that will be exacerbated in coming years by the aging of the baby boom generation and their need for surgical services.

12902 Magnolia Drive
Tampa, Florida 33612-9497
Phone: (813) 972-8486
Fax: (813) 979-3064

vilah@moffitt.usf.edu
www.moffitt.usf.edu

The proposed policy revision will not affect in any way the education of Certified Registered Nurse Anesthetist (CRNA) students or the number of CRNA students trained at our institution.

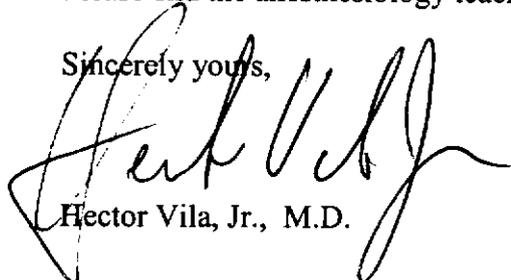
Under current Medicare regulations, teaching surgeons and even internists are permitted to work with residents on overlapping cases and receive full payment so long as the teacher is present for critical or key portions of the procedure. Teaching surgeons may bill Medicare for full reimbursement for each of the two procedures in which he or she is involved. An internist may supervise residents in four overlapping office visits and collect 100% of the fee when certain requirements are met.

Teaching anesthesiologists are also permitted to work with residents on overlapping cases so long as they are present for critical or key portions of the procedure. However, unlike teaching surgeons and internists, since 1995 the teaching anesthesiologists who work with residents on overlapping cases face a discriminatory payment penalty for each case. The Medicare payment for each case is reduced 50%. This penalty is not fair, and it is not reasonable.

Correcting this inequity will go a long way toward assuring the application of Medicare's teaching payment rules consistently across medical specialties and toward assuring that anesthesiology teaching is reimbursed on par with other teaching physicians.

Please end the anesthesiology teaching payment penalty.

Sincerely yours,



Hector Vila, Jr., M.D.



SCOTTS VALLEY FIRE PROTECTION DISTRICT

SEP 15 2005

391

7 Erba Lane, Scotts Valley, California 95066 (831) 438-0211 Fax (831) 438-0383

September 12, 2005

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1502-P
P.O. Box 8017
Baltimore, MD 21244-8017

Re: File Code CMS1502-P

Issue Identifier: GPCI's/Payment Localities

Dear Sir:

I am writing on behalf of the Scotts Valley Fire Protection District to strongly support your proposed revision to physician payment localities in California, recently published in the reference rule. Scotts Valley Fire Protection District is writing to express our concern about the viability of the health care system which serves our residents. The great difference between the cost of medical practice in Santa Cruz County as measured by BAF cost values and the low rate of reimbursement due to being assigned to Locality 99 has made recruitment and retention of physicians willing to serve Medicare beneficiaries very difficult.

We were pleased to see that your proposed rule would alleviate this problem by removing Santa Cruz and Sonoma Counties from Locality 99 and placing them into unique localities. We laud your efforts to rectify this long-standing inequity. Your proposal will be of great help in ensuring access to emergency and other services. We believe the proposed rule to be fair. Neighboring counties to Santa Cruz and Sonoma have some of the highest payment levels for physicians in the nation. The adjustment you propose appropriately addresses this payment imbalance. This revision would bring you closer to your goal of reimbursing physicians based on the cost of practice in their locality.

Sincerely,

A handwritten signature in black ink, appearing to read "Michael P. McMurry".

Michael P. McMurry
Fire Chief



SEP 15 2005

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F I R E D E P A R T M E N T

230 Walnut Avenue, Santa Cruz, CA 95060 • 831 420-5280 • FAX: 831 420-5281

September 9, 2005

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1502-P
P. O. Box 8017
Baltimore, MD 21244-8017

Re. File Code CMS1502-P

Issue Identifier: GPCI's / Payment Localities

To Whom It May Concern:

I am writing on behalf of the City of Santa Cruz Fire Department to strongly support your proposed revision to physician payment localities in California, recently published in the reference rule. As the city's fire chief and EMS administrator, I am writing to express our concern about the viability of the health care system which serves our residents. The great difference between the cost of medical practice in Santa Cruz County, as measured by BAF cost values and the low rate of reimbursement due to being assigned to Locality 99, has made recruitment and retention of physicians willing to serve Medicare beneficiaries very difficult.

We were pleased to see that your proposed rule would alleviate this problem by removing Santa Cruz and Sonoma counties from Locality 99 and placing them into unique localities. We laud your efforts to rectify this long-standing inequity. Your proposal will be of great help in ensuring access to necessary health care services. We believe the proposed rule to be fair. Neighboring counties to Santa Cruz and Sonoma have some of the highest payment levels for physicians in the nation. The adjustment you propose appropriately addresses this payment imbalance. This revision would bring you closer to your goal of reimbursing physicians based on the cost of practice in their locality.

Sincerely,

Ron Prince
Fire Chief

SEP 15 2005 343



Suntrek Tours Inc. International Adventure Tour Operator
Sun Plaza, 77 West Third Street, Santa Rosa, CA 95401 / USA
Phone 707-523-1800, Fax 707-523-1911
Reservations 1-800-SUNTREK, E-mail: suntrek@suntrek.com,
<http://www.suntrek.com>

September 9, 2005



USA



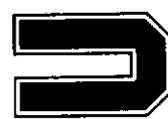
ALASKA



CANADA



MEXICO



HAWAII



Adventure & Fun

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1502-P
PO Box 8017
Baltimore, MD 21244-8017

Re: GPCIs

I understand that Medicare is proposing to create a new payment locality for Sonoma County, California. I would like to address some specific concerns from the perspective of Suntrek Tours Inc:

- Santa Rosa now ranks with retirement destinations such as Clearwater, St. Petersburg, and Miami, Florida.
- Among cities with a population of 100,000 or more, Santa Rosa is sixth in the United States for the highest percentage of people 85 and older.
- According to State of California Department of Finance, seniors 60 and older represent 16.6% of the total population in Sonoma County, with a projected rate of change of 196% by 2020.

Amid the astounding growth in our elder population, Sonoma County is facing strains on the health care delivery network that are unacceptable to Medicare recipients:

- The number of practicing physicians in Sonoma County has not kept pace with local population growth. From 1995 to 2002, the population increased 13%, but the number of practicing physicians increased by only 4%.
- As of July 2005, 60% of Sonoma County primary care physicians were NOT accepting new Medicare patients.
- Many physicians are leaving our county to practice where reimbursement is more favorable. As a result, many specialties are under-supplied. For example, we have only two gerontologists in the county for more than 76,000 seniors.

The new locality would increase the Medicare reimbursement rate to more closely match actual practice expenses, helping Sonoma County physicians improve the quantity and quality of care they deliver to Medicare beneficiaries and other patients. The locality change would also aid efforts to recruit and retain physicians in the county, which has a large Medicare population. I fully support your proposal to change Sonoma County's payment locality, and I appreciate the opportunity to comment on this important issue.

Sincerely,
SUNTREK TOURS INC



Daniel Hildebrand
President

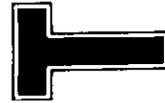
cc: Two copies attached



USA



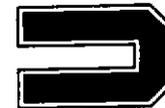
ALASKA



CANADA



MEXICO



HAWAII



*Adventure
& Fun!*

SEP 15 2005

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R. Steven Vargas, M.D.

K. Daniel Rose, M.D.

FAMILY MEDICINE

September 12, 2005

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS 1502 P
P.O. Box 8017
Baltimore, MD 21244-8017

Re: GPCI's

I am a physician practicing an unusual time when it comes to treating Medicare patients. I am paid significantly less for taking care of these patients than my colleagues in neighboring Napa and Marin counties, only a few miles away. Those physician colleagues and I all share the same economic costs of delivering health care and a very high cost of living common here in the San Francisco Bay Area. Because of antiquated rules and regulations, Sonoma County physicians are underpaid significantly by more than 10% and our Medicare patients are suffering as a result.

I accept Medicare patients, as part of my responsibility to serve my community. However, since my arrival to Sonoma County 7 years ago, I have witnessed an outflow of 26 internal medicine and family physicians while only four of those left for retirement. Others left for greener pastures and better pay elsewhere. I am still the newest physician in my region, with 7 years experience here, except for two young doctors who are here on a salary guarantee for two years. After that time, it remains to be seen if they will leave the area, as their predecessors did, because they learn they can make much more money in other areas while doing the same amount of work. The exodus of physicians in our area, due in a large part to the low Medicare reimbursement we currently experience, has resulted in a physician shortage and a barrier for seniors who want to obtain quality health care from doctors near their homes.

As a practicing family physician in Sonoma County and Vice Chief of Staff at Healdsburg District Hospital, former hospital board member and community volunteer, I strongly support and request your vociferous support for the proposal to create a new payment locality for Sonoma County. The new locality would lessen the disparity between practice expenses and Medicare reimbursements and have a far-reaching effect of improving reimbursement, making the area more attractive for physicians and improving access to care for our seniors.

As you may know, many Medicare recipients are embarrassed by the low reimbursement their doctors receive for their care. Often, Medicare reimbursements don't even cover expenses, which is why so many physicians don't want to accept any new Medicare patients. The current proposal will help correct some of the existing payment inequities and will help you achieve your goal of reimbursing physicians based on the cost of practice in their locality.

Thank you for the opportunity to comment on this important issue. Please support GPCIs.

Sincerely,

R. Steven Vargas, MD

Cc: Two copies attached



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September 5, 2005

Centers for Medicare & Medicaid Services
Department of Health and Human Services

Attention CMS-1502-P
P.O. Box 8017
Baltimore , MD 21244-8017

CPCI

I am writing this letter to protest the totally unfair situation we have in Santa Cruz County in California. For several decades this County has been designated as a "RURAL" area. The designation as "Rural" has made it difficult to attract and retain doctors with special capabilities. The higher rate of Medicare coverage within the "Urban" Counties makes it difficult to retain various medical specialists. Our designation of "Rural" makes it difficult to compete. Many injuries such as head, brain and others are taken by helicopter to the other "Urban" Counties where the "Specialists" are practicing. According to our daily newspaper, "SANTA CLARA COUNTY BECOMES, in 2005, THE HIGHEST PAID COUNTY IN THE U.S. BECAUSE OF ITS INHERENTLY HIGH PHYSICIAN PRACTICE EXPENSES. AND THAT IS AS IT SHOULD BE, BUT ONLY BECAUSE IT WAS PROPERLY DEFINED AS "URBAN" IN 1967. YET THE SAME ECONOMIC CHANGES IN SANTA CRUZ COUNTY ARE IGNORED." Many of our Doctors and Specialists simply can't afford to stay in Santa Cruz, so they go over the hill where they can receive proper compensation for their specialties and abilities.

This is a situation that should be remedied! It doesn't make any sense to me! I request that a sincere effort be made to correct our designation and change it to "Urban" for which I believe it qualifies. The seriously injured and those with chronic ailments would no longer be required to go over the mountain to the "Big City" in order to get needed medical attention. I believe, that if the current trend continues and we remain a "Rural" designation, many people living in Santa Cruz County will be unable to afford the cost of adequate medical expertise and will not have the capability to travel over the hill to the "Big City". I sincerely hope that you will consider my request.

I look forward to and will appreciate a response.


William Hardwick
687 Paradise Park
Santa Cruz, CA
95060

DHPPC



THE UNIVERSITY OF CHICAGO
Department of Anesthesia and Critical Care
5841 South Maryland Avenue, MC 4028
Chicago, Illinois 60637

ME - Register
570359
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SEP 16 2005

Telephone: (773) 702-2545
Facsimile: (773) 702-2190
j-apfelbaum@uchicago.edu

Jeffrey L. Apfelbaum, M.D.
Professor and Chairman
Department of Anesthesia and Critical Care
The University of Chicago Hospitals
Pritzker School of Medicine

September 8, 2005

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P/TEACHING ANESTHESIOLOGISTS
P.O. Box 8017
Baltimore, MD 21244-8017

2005 SEP 14 11:19:08

Dear Dr. McClellan:

As an academic anesthesiologist at The University of Chicago, I am writing to you because of my grave concern for the safety of patients who are in need of care by physicians in the medical specialty of anesthesiology. Specifically, I write to urge you to immediately advocate for change to the Medicare anesthesiology teaching payment policy.

Current policies from the Centers for Medicare and Medicaid Services (CMS) regarding reimbursement under the Medicare teaching anesthesiology payment rule are unwise, unsustainable, and endanger an ever increasing elderly Medicare population; Medicare's discriminatory payment arrangement, which applies only to anesthesiology teaching programs, has had a serious detrimental impact on the ability of training programs to retain skilled faculty and to recruit the next generation of specialists. The current shortage will be exacerbated in coming years by the aging of the "baby-boom generation" and their need for anesthesiology services in the provision of interventional care, surgical care, critical care, and pain medicine. Simply put, anesthesiology teaching programs throughout the United States are suffering severe economic losses that simply cannot be absorbed elsewhere in today's healthcare system. Since 1995, teaching anesthesiologists who work with residents on overlapping cases (even if such overlap is for only 1 minute per case) face a 50% discriminatory payment penalty for each case. This penalty is not fair, and is not reasonable; if it continues without your intervention, the current shortage of physicians in the medical specialty of anesthesiology will become a crisis.

est that you consider eliminating this inequity and assure
care's teaching payment rules consistently across all
permitting anesthesiology teaching to be reimbursed on par
y physician teaching.

your consideration.


Jeffrey L. Apfelbaum, M.D.
Professor and Chairman
Anesthesia and Critical Care

SEP 16 2005

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Sept. 7, 2005

Center for Medicare/Medicaid Services

As a resident of Sonoma County, I am urging Medicare to approve the proposed new rule to increase reimbursements for medical services. Our County is losing doctors because of low reimbursements. Many are refusing Medicare patients. Many are retiring earlier than they desired. Many are moving from our county.

Please stop treating our County as a small rural community. Bring medical reimbursements to the level deserved.

Thank you for your attention to our county's needs.

Bob Sorani
4175 SONOMA Mtn. Rd.
SANTA ROSA, CA 95404

Sharon Sorani
4175 Sonoma Mtn. Rd.
Santa Rosa, Ca, 95404

SEP 16 200



Mr. Ralph Piper
350 Petaluma Avenue
Sonoma, CA 95476

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SEPT. 6, 2005

GPCIS
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPT OF HEALTH & HUMAN SERVICES
ATT: CMS-1052-P
P.O. BOX 8017
BALTIMORE, MD 21244-8017

DEAR SIRs,

I BELIEVE THAT MEDICARE IS TAKING A POSITIVE STEP IN PROPOSING AN INCREASE OF 8% IN THE REIMBURSEMENT RATE FOR DOCTORS IN SONOMA COUNTY.

MEDIA HAS REPORTED THAT SONOMA COUNTY HAS ONE OF THE HIGHEST PERCENTAGES OF SENIORS IN THE COUNTRY, BUT THE LOWEST MEDICARE REIMBURSEMENT RATES IN CALIFORNIA.

IN CONSEQUENCE, I STRONGLY SUPPORT BRINGING SONOMA COUNTY IN LINE WITH CURRENT MEDICARE REIMBURSEMENT RATES FOR OTHER COUNTIES, BY AN INCREASE OF 8%.

AS A VOLUNTEER IN THE LOCAL SONOMA VALLEY HOSPITAL, I HAVE HEARD COMMENTS ABOUT DIFFICULTIES IN ENCOURAGING NEW DOCTORS LOCATING TO THIS AREA - PARTLY DUE TO LOWER MEDICARE REIMBURSEMENT.

VERY TRULY YOURS,
Ralph W. Piper
RALPH W. PIPER



**UNIVERSITY OF
PENNSYLVANIA
HEALTH SYSTEM**

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Department of Anesthesiology and Critical Care

August 29, 2005

SEP 16 2005

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1502-P
P.O. Box 8017
Baltimore, MD 21244-8017

RE: Teaching Anesthesiologists

To Whom It May Concern:

I am writing in reference to the current Medicare teaching anesthesiologist's payment rule, which is unwise, unfair, and unsustainable. Quality medical care, patient safety, and an increasingly elderly Medicare population demand that the United States has a stable and growing pool of physicians trained in anesthesiology. There is a national priority on reducing surgical complications by 25% over the next five years. Many of these strategies involve anesthesiologists, both in the operating room and outside of the operating room. They require subspecialty trained physicians, including intensivists, who are exclusively derived from the physician pool. Additionally, chronic pain is increasingly common in the Medicare population, and anesthesiology is one of the primary routes by which physicians are further trained in pain management.

Currently, slots in anesthesiology resident programs are going unfilled because of an ill-conceived Medicare policy that shortchanges teaching programs, withholding 50% of their funds for concurrent cases. The Department of Anesthesiology and Critical Care at the University of Pennsylvania School of Medicine currently trains 72 residents and approximately 10 additional fellows in critical care, chronic pain management, and cardiovascular anesthesiology. We have a faculty of over 62 physicians, with several faculty openings.

As outlined above, the Medicare teaching anesthesiologist rule significantly impacts our academic departments and their ability to sustain economic viability. This has driven most research and advancement out of the academic departments. As the Institute of Medicine report has recently emphasized, anesthesiology is a field which has shown the greatest improvement in patient safety. As CMS is well aware, quality of care is usually cost effective, and although adverse intraoperative events directly attributable to anesthesiology have decreased, anesthesiologists continue to perform research which would effect the entire perioperative continuum and decrease overall complication rates, including such interventions as appropriate antibiotic timing, perioperative glucose control, and numerous interventions to reduce pulmonary complications. Again, many of these strategies are targeted to the highest risk and most vulnerable patients who seek teaching hospitals as the most appropriate venue for care. Therefore, this arbitrary Medicare payment reduction, which is not in line

with the surgical fee schedule (in which the surgeon receives 100% of the fee for each case in Medicare), will lead to stagnation in perioperative advancements which could improve patient care and theoretically reduce overall healthcare costs.

CMS must recognize the unique delivery of anesthesia care, and pay Medicare teaching anesthesiologists on par with their surgical colleagues. The Medicare anesthesia conversion factor is less than 40% of prevailing commercial rates. Reducing that by 50% for teaching anesthesiologists results in revenue grossly inadequate to sustain the service, teaching, and research missions of academic anesthesia training programs. The net result will be a reduction in advancements in quality of care that have been the hallmark of academic anesthesia during the last 50 years. If you have any questions, please feel free to contact me.

Sincerely,

A handwritten signature in black ink, appearing to read "C. William Hanson III". The signature is fluid and cursive, with a large initial "C" and "W".

C. William Hanson III, M.D
Professor of Anesthesia, Surgery and Internal Medicine,
Medical Director, Surgical Intensive Care Unit Section Chief, Critical Care Medicine

SEP 16 2005

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Sept 8, 2005

Medicare and Medicaid Services —

I am writing to ask you to please increase the Medicare reimbursement in Sonoma County, NOW!

I am as is my husband are in total support of the 8% increase to our Doctors here in Sonoma County.

There are now many Doctors in Sonoma County (6 out of 10) not accepting new Medicare pts. We have many seniors.

An increase in reimbursements is needed NOW! Please act quickly.

Thank You

Sincerely

Olivia Siqueira